Families in multiple family therapy for adolescent anorexia nervosa : response to treatment experience and family and individual change

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FAMILIES IN MULTIPLE FAMILY THERAPY FOR ADOLESCENT ANOREXIA NERVOSA:

RESPONSE TO TREATMENT, TREATMENT EXPERIENCE AND FAMILY AND INDIVIDUAL CHANGE

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ABSTRACT

This thesis reports on a family treatment study of adolescent anorexia nervosa. The treatment under investigation is the newly developed approach of Multiple Family Therapy (MFT) for anorexia nervosa. Thirty patients and their families are evaluated at entry to the treatment and regular intervals throughout. The aims of the study involve the assessment of changes within the individual and the family during treatment and the exploration of their perceptions of the therapeutic process. Quantitative and Qualitative methods are employed to address these issues.

This thesis is divided into four parts. The first part consists of a review of the literature. Firstly, the psychopathology of anorexia nervosa is discussed in terms of historical development of the concept, diagnosis and classification as well as relevant epidemiological findings. In turn, the influence of the family in the development and treatment of anorexia nervosa is addressed. The development of MFT and its relevance to eating disorders is also presented as well as literature on patient satisfaction and helpful events in psychotherapy. The rationale for combining quantitative and qualitative methods in the present study and an overview of methodology are also presented.

In the second part of the study the qualitative accounts of patients' and parents' treatment experiences are described. Both parents and patients mainly reported helpful aspects being associated with the treatment. Main themes involved the mutual support, feedback and identification between the families as well as changes perceived to have occurred as a result of the MFT. These involved the parents' increased sense of self efficacy in their parental role, ability to contribute in their child's recovery, enhanced communication within the family as well as increased understanding of the condition and empathy with the patient.

The third part of the thesis represents the quantitative component of the study where the relevant methodology is presented and results reported and discussed. In this respect, patients clearly improved during MFT across all variables assessed. Some change was observed in the family level with parental criticism towards the patient decreasing while warmth between the parents increasing. Reduction in paternal critical attitude and increase in his involvement with the patient were associated with more weight gain. Families also reported high client satisfaction with the treatment. Results are discussed with reference to family processes in anorexia nervosa as well as with respect to the MFT's efficacy in facilitating individual and family change.

Quantitative and qualitative findings are brought together in the last part of the thesis.

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PART I

LITERATURE REVIEW AND OVERVIEW OF METHODOLOGY

CHAPTER 1

ANOREXIA NERVOSA

1.1) DEVELOPMENT OF THE CONCEPT

Despite the rather prevalent lay belief that anorexia nervosa is a disorder of the 20th century, clinical descriptions of the features of the illness can be traced back to 1694 with Richard Morton's (1964) reference to an illness described as a "Nervous Consumption". Morton's account of the two relevant case histories was that the illness was caused by "sadness and anxious cares". A similar diagnosis was made by Whytt in 1764 on a teenage boy described to be suffering by a "Nervous Atrophy".

A more elaborate description was presented by Louis-Victor Marce (1860) on a group of female patients presenting with dyspepsia in the form of "absence of appetite or by the uneasiness caused by digestion" which led him to conclude that in that instance "food avoidance was psychological in character". Seeing the illness as a "hypochondriacal delirium" Marce's account of his patients was that "they are no longer dyspeptics - they are insane".

A more robust and systematic description of the illness, including many of the features familiar to the contemporary clinician were presented by Laseque (1873) and Gull (1874)

in their respective formulations of "l' anorexie hysterique" and "anorexia nervosa". Both clinicians described an illness of inexplicable origin characterised by extreme weight loss and severe emaciation as well as the lack of menstruation. In addition to the above description of the physical symptoms of the illness, "a morbid mental state" was described by Gull (1874) and a "hysterical anorexia" by Laseque (1873) while both clinicians commented on "a mental perversity".

Most researchers and clinicians within the eating disorder field would recognise the core features of anorexia nervosa in these early descriptions provided by Gull and Laseque and this is despite the many years between the patients of these early observers and the patients encountered at current eating disorders services.

The one feature, however, that was not present in these early descriptions (but which is central to current accounts) is the patients' fear of fatness and morbid preoccupation with body weight as the core features of anorexia nervosa psychopathology. Bruch (1963) observed the "patient's disturbed experience of her own body", Crisp (1970) noted his patients' "weight phobia" and similarly Russell (1970) described the patients' "morbid fear of fatness".

An explanation offered to account for the fear of fatness lacking from Gull's and Laseque's descriptions was that anorexia nervosa has changed since the 1870s (Russell & Treasure, 1989; Russell, 1985; 1985) In other words, the fact that the illness evolves within a general population which is also changing with respect to ideal body figure. Women's fashion

magazines are a source thought to be reflecting tendencies regarding perceived ideal figure. In a study where mean bust-to-waist ratios of models appearing in *Vogue* and *Ladies Home Journal* in issues from 1901-1981 were measured two periods have been identified when the bust-to waist ratios have steadily diminished. The first such period was between 1909 and 1929 but in the lack of statistics on the incidence of anorexia no relevant conclusions can be drawn. The second period characterised by a fall in the above measure of thinness was from 1949-1981 corresponding to the increase of anorexia (Silversein et al., 1986).

Similarly, Garner and colleagues (Garner & Garfinkel, 1980) recorded weights of contestants for the Miss America Pageant from 1959-1978 and in comparison with national norms indicated that beauty contestants' average weights were well below the national norm while a negative correlation was found between the year of entry and percentage average weight indicating an average decline in weight of 0.13 kg for each year during 1959-1978. The authors concluded that there has been a clear shift towards a thinner ideal shape for women over the 20 years of 1959-1978 and that these changes in ideal weight occurred in the context of increasing weight norms for the general population.

It is relevant to note Russell's (Russell, 1985; 1995) suggestion that fear of fatness and body weight preoccupation should be seen as pathoplastic elements associated with socio-cultural influences rather than a pathogenic feature of the illness.

Following-up on Russell's (1985, 1995) idea, Theander (1995) reviewed the early descriptions of anorexia nervosa, to include those of Marce, Gull and Laseque. Triggered

by Russell's above mentioned argument Theander in his review tried to identify the symptoms and manifestations of the illness in those early writings that exhibited continuity over time; these were "the marked preponderance of females and young people among the patients; food refusal; the extreme, often life-threatening emaciation, but also the tendency to recover; and the denial of illness".

Overall, from what was considered so far, it appears that Gull's and Laseque's original accounts capture the essence of the illness, while more recent observations reflect societal changes affecting the ways the illness is expressed by the vulnerable individual rather than changes in the psychopathology of the illness itself. Most importantly though anorexia seems to be an illness that is not static through time and corresponding societal and other changes. Despite the core features of the illness being similar throughout the years, the way anorexia manifests it self and thus the way it is experienced by the patients and those around them changes. This needs to be taken into account by clinicians/researchers when construing diagnostic criteria, aetiological models and treatment approaches.

1.2) DIAGNOSTIC CRITERIA AND CLASSIFICATION

Various methods of diagnosis and classifications have been suggested for anorexia nervosa which is perhaps symptomatic of the variety of biological symptoms and psychological manifestations of the illness as well as the differing perceptions of clinicians/researchers regarding the importance of them in actually defining the illness.

Bruch (1961) coming from a psychodynamic tradition suggested a psychological approach to diagnosis to include body image disturbance, an overwhelming feeling of ineffectiveness and loss of awareness of interoceptive cues as the core features of the illness. Although this approach adequately captures the psychological aspects of the illness, it lacks reference to the physical symptoms so central to the illness.

More standardised diagnostic schedules were proposed towards the end of the 1960s (Dally, 1969; Feifhner et al., 1972; Russell, 1970) which aimed to include both the physical symptoms as well as behavioural and psychological manifestations of the illness (table 1).

TABLE 1 Early Diagnostic Schedules for Anorexia Nervosa

Dally (1969)

A: Refusal to eat enough to maintain normal weight and/or sustained efforts to prevent ingested food from being absorbed.

B: Loss of at least 10% of previous body weight.

C: Amenhorrhea of at least 3 months or if menstruation had been irregular a period of amenhorrhea of at least 6 months.

D: Onset between age 12 and 39 years.

E: No organic disease, serious affective disorder or schizophrenia.

Russell (1970)

A: Behaviour leading to marked loss of body weight. A studied avoidance of foods considered to be of a fattening nature. Often but not invariably the subject resorts to additional devices ensuring loss of weight: self-induced vomiting or purgation, or excessive exercise. Occasional bouts of overeating may occur.

B: An endocrine disorder-amenhorrhea in the female and loss of sexual interest in the male.

C: A morbid fear of becoming fat which may be fully expressed by the subject or may be more explicit in her behaviour. To safeguard herself against what she calls "loss of control" –that is not being able to stop eating- she strives to remain abnormally thin.

D: A specific degree of weight loss is required-20% of standard body weight.

Feighner et al (1972)

A: Onset prior to the age of 25 years.

B: Anorexia with weight loss of at least 25% of original body weight.

C: A distorted, implacable attitude towards eating, food or weight that overrides hunger, admonitions, reassurances or threats. This could include: denial of the illness with a failure to recognise nutritional needs; apparent enjoyment of weight loss and food refusal; a desired body image of extreme thinness; unusual handling or hoarding of food.

D: No known medical illness.

E: No other known psychiatric disorder.

F: At least two of the following: ammenorrhea, lanugo hair, bradycardia (persistenresting pulse of 60 or less).

The classification schedules noted above are similar in terms of the food refusal and associated endocrine syndrome of amenorrhea but rather different in terms of features regarding fear of fatness, body image disturbance and food related as well as compensatory behaviours leading thus to different diagnostic conclusions.

Nevertheless, they constitute a valuable effort towards a systematised way of assessment of anorexia nervosa and thus it is not surprising that most of the criteria outlined above are of relevance to the DSM–IV Criteria for anorexia nervosa (table 2)

Table 2. DSM-IV Criteria for Anorexia Nervosa (APA, 1994)

A: Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

B: Intense fear of gaining weight or becoming fat, even though underweight.

C: Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D: In postmenarchal females amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

The most central features of anorexia nervosa thus are the maintenance of an abnormally low body weight, reflecting attitudinal and behavioural responses to the morbid fear of fatness. It is worth noting though that although the anorexic patient appears to be rigid and

over-controlling, especially with respect to food, she invariably sees herself as being out of control. This rather paradoxical observation has given rise to the idea that the drive for thinness, so characteristic of the illness, is actually secondary to concerns of being out of control (Bruch, 1970) as well as fears regarding the consequences of a normal body weight (Crisp, 1970).

With respect to the disturbance in which body weight and shape is experienced by sufferers with anorexia it worth referring to the evidence suggesting that anorexic patients also have a tendency to misperceive their affective and bodily sensations (Bruch, 1977). Body image distortion can, therefore, be seen as reflecting a more general difficulty with thinking and perceptual processes.

There is a range of other phenomena affecting mood or food related behaviours, which do not constitute diagnostic criteria but are nevertheless ascribed to the anorexic syndrome. An important point to be made though is that such phenomena are observable in most people who are in a state of starvation and are not unique to sufferers of anorexia (Casper & Davies, 1977). A series of studies known as the Minnesota Studies (Keys et al., 1950) were conducted with a sample of psychologically normal men put on semi-starvation diet for a six month period and revealed that the subjects tended to approach food with great secrecy and rituals, had an intense preoccupation with food and also showed other strange food habits such as stealing small pieces of food and combining odd mixtures of food. Similarly, prolonged food restriction is associated with irritability, depression, anxiety, poor concentration, fatigue and apathy - all features familiar to sufferers of anorexia nervosa (Garfinkel & Garner, 1982)

1.3) MAGNITUDE AND SERIOUSNESS OF ANOREXIA NERVOSA

An important step that followed the development of the standardisation of anorexia nervosa diagnosis was the pursuit of epidemiological research in the field which provided important information on how big the problem is. Van Hoeken and colleagues (Van Hoeken et al., 2003) have recently conducted a review of epidemiological research in eating disorders. In terms of prevalence of anorexia nervosa in young females and based on twelve studies of general practice and school populations between the years of 1981 and 2000 the authors report prevalence rates ranging from 0% to 5% and report and average rate of 3%.

In terms of incidence and having reviewed 13 studies covering the years between 1931 and 1993 that used a variety of sources (hospital and medical records, case registers, and general practitioners) report variable rates per 100 000 population per year, ranging from 0.10 in a hospital record study conducted in Sweden in the early 1930s (Theander, 1970) to 8.3 per 100 000 population in a medical records study in the 1980s USA (Lucas et al., 1999). Despite the observed variability Van Hoeken and colleagues (Van Hoeken et al., 2003) concluded that over the past 50 years the incidence of anorexia nervosa has increased and this is particularly the case in females between 10 and 24 years of age. It is unclear though whether this represents an actual increase in the number of individuals afflicted or does not reflect, at least partly, an increased number of formal anorexia nervosa diagnoses in the last decades resultant to the advances in standardisation of diagnostic procedures discussed earlier.

Anorexia nervosa also has a relatively high mortality rate as indicated by both Crude (CMR) and Standardised Mortality Rates (SMR). In terms of CMR, Sullivan (Lucas et al., 1999; Sullivan, 1995) in a meta-analysis of 42 studies found a mortality rate of 5.9 (178 deaths in 3006 patients) while from the studies specifying causes of death it was indicated that 54% of the patients died as a result of anorexia nervosa complications, 27% committed suicide and 19% died of unknown causes. As for SMR Nielsen (2001) in an update of a previous meta-analysis reported an overall SMR of 9.6 in studies of 6 to 12 years follow-up and 3.7 in studies with follow-ups of 20 to 40 years and therefore concluded that the risk of dying for patients with anorexia nervosa is almost four-fold compared to healthy individuals of the same age and sex.

Needless to say that the risk of dying is the ultimate and most frightening aspect of anorexia nervosa and with this respect the results of a substantial number of studies evaluating the outcome of children, adolescents and young adults suffering with the condition are quite encouraging indicating that about half to two thirds of the patients achieve a good outcome, at least in terms of weight and nutritional status, while about one third remain underweight and a very small proportion of the patients becoming obese(Bryant-Waugh et al., 1996; Bryant-Waugh et al., 1988; Garfinkel & Moldofsky, 1977; Hsu et al., 1992; Ratnasuriya, et al., 1991; Steinhausen et al., 1991).

Nevertheless, and despite the encouraging outcome literature, anorexia nervosa is an illness with potential serious medical complications some of which reversible and some irreversible despite weight gain(Zipfel et al., 2003; Treasure & Szmukler, 1995) while the

effects of the illness in compromising the patients' and their families' social life and functioning as well as their emotional well-being (e.g. Nielsen & Bara-Carril, 2003; (Schmidt et al., 1995) are no less devastating.

All of the above as well as the fact that anorexia nervosa has been identified as the third commonest chronic condition in adolescence (Lucas et al., 1999) reflect the seriousness of the illness for both the patient and those around him/her as well as highlight the need for the development and provision of effective and acceptable treatments that will help patients recover within as short a period as possible and with as little residual medical, emotional and social compromises in the patients' later life.

1.4) CONCLUDING REMARKS OF CHAPTER 1

From what has been discussed so far it appears that anorexia nervosa is not a recently emerged illness while its originally observed clinical features bare great similarity to the presentation of anorexia nervosa sufferers today. Nevertheless, anorexia nervosa is not static through time as its clinical presentation, despite maintaining the original characteristics, changes over time, possibly reflecting changes that take place in our ever changing society. An important step forward has been the development and establishment of comprehensive classification schedules for anorexia nervosa, facilitating screening and formal diagnoses and therefore the provision of care and treatment for the sufferers. Epidemiological and outcome research has been a further step of great usefulness with respect to our current understanding of the magnitude of the problem as well as the potential for recovery. Overall, although anorexia nervosa is not very prevalent within the general population it is one of the commonest chronic conditions in adolescence;

nevertheless findings from outcome research on adolescent patients' weight restoration are quite encouraging. These, along with the serious consequences of the illness ranging from compromised social and emotional well being to medical complications and the ultimate risk of dying highlight the need for the development of appropriate interventions that will facilitate recovery and prevent the illness from taking a chronic course that will extent from adolescence to adulthood further compromising the patients' life and well-being.

CHAPTER 2

FAMILIES IN ANOREXIA NERVOSA

In this chapter the role of the family in the development and treatment of anorexia nervosa will be examined. Accounts of families of anorexic patients will be presented starting from as early observations as those of Gull and Laseque through traditional psychoanalytic and object relations observations to more comprehensive accounts of these families coming from family systems theorists. The evidence for the usefulness of the family in the treatment of anorexia nervosa will be reviewed as well as the evidence for the existence of pathology within eating disorders families. The final section will attempt to bring together family factors and their possible role in family therapy.

2.1) FAMILIES IN THE DEVELOPMENT OF ANOREXIA NERVOSA

a) Early descriptions of anorexia nervosa families

Speculations about the influence of the family in the genesis of anorexia nervosa date back to Louis Victor-Marce's (1860) description of the illness who thought that 'hereditary antecedents' played a determinant role in predisposing certain young people to develop 'hypochondriacal insanity', an illness baring great resemblance to our current conceptualisation of anorexia nervosa (Silverman, 1989).

There was consensus among the early observers that the influence of the family who lacked "moral control" over the patient was harmful (Gull, 1874; Laseque, 1873; Charcot, 1889). The tendency to ascribe a crucial role to the family as an agent causing and maintaining the illness is clearly illustrated in Laseque's (1873) passage: *" The relatives and friends begin to regard the case as desperate. It must not cause surprise to find me thus always placing*

in parallel the morbid condition of the hysterical subject and preoccupations of those who surround her. These two circumstances are intimately connected and we should not thus acquire an erroneous idea of the disease by confining ourselves to an examination of the patient...the moral medium amidst which the patient lives exercises an influence which it would be equally regrettable to overlook or misunderstand"(Laseque, 1873; p.152).

The perceived harmful effect of the family upon the anorexic patient lead to the exclusion of the parents from any therapeutic approach to be adopted, later referred to as 'parentectomy' (Harper, 1983; Peshkin & Tuft, 1956) the rational for which is evident in (Charcot, 1889) words: *"It is necessary to separate both children and adults from their father and mother, whose influence, as experience teaches, is particularly pernicious"(Charcot, 1889; p.210).*

Families of anorexic patients continued to be portrayed as dysfunctional maintaining the assumption that parents play a central role in the pathogenesis of anorexia nervosa and should thus be excluded from treatment. Despite the lack of evidence for the harmful processes taking place within anorexic families separating the patient from her parents subsequently governed relevant therapeutic approaches for many decades.

The first systematic accounts of processes in families containing an anorexic member, to follow the above early observations, were those of psychoanalytical insights initially focusing on theories about fixation at the oral stage of psychosexual development and

regression from the genital to the oral stage and on symptom formation around oral conflicts (Ross, 1977).

Benedek (1936) for instance elaborated on the analysis of an anorexic patient with oral aggression aimed towards the mother's breast. Waller and colleagues (1940) emphasised the role of symbolisation of impregnation fantasies involving the gastrointestinal track while later authors extended this theory suggesting that anorexia nervosa had a defensive function as to the guilt associated with these impregnation fantasies (Blitzer et al., 1961; Sandler & Dare, 1970).

Other authors from the psychoanalytic tradition have described cases in which similar distortions at the symbolic level were thought to produce the striving for weight loss (Lonard, 1943; Moulton, 1942; Szyrynski, 1973). With this respect, the mothers of anorexic patients were described as over-involved, dominant while emotionally unavailable and the fathers as detached and playing a marginal role in family life (Bliss & Branch, 1960; Szyrynski, 1973)

One of the most representative accounts of this drive related viewpoint was that offered by Thoma (1967) who postulated that anorexia results from the patient having left the genital stage of development with a predominance of 'oral ambivalence'. In that instance the primary defence is against sexual fears which are displaced into concerns about body size.

As more recent psychodynamic insights have shifted from drive theory into object relations so did the relevant accounts regarding the familial influences on the development of an eating disorder (Bruch, 1973; Ross, 1977; Selvini-Palazzoli, 1974; Sours, 1974) with the

most influential such accounts being provided by Bruch (1963) and Mara Selvini-Palazzoli (1974) to be described below.

It is interesting to note here that no systematic investigation of family processes in eating disordered patients was reported until 1940, when Bruch and Touraine (1940) mainly concerned with childhood obesity, conducted a study suggesting that there was some disturbance in the psychological climate of these families.

Later on and primarily working with individual anorexia nervosa patients Bruch (1973) postulated that dysfunctional patterns of early mother-child relationship, which continue through adolescence, are central in the genesis of anorexia nervosa which develops around the 3 following inter related ego disturbances: distortions of body image, internal perceptions and a sense of ineffectiveness.

The central theme of Bruch's formulation is that anorexia represents the patients attempts towards self-mastery, autonomy and differentiation from her own mother which is pursued maladaptively through rigid control over her starving body.

Bruch's conception of this development involves mother-child interactions thought to be significant from birth on as well as factors within the patient herself.

She proposed that anorexic patients have deficits in self-initiated behaviours and this is in part related to an experienced neglect of appropriate responses to the child's inner states. This however is not to say that patients who develop anorexia were neglected by their primary carer as children. Bruch's theory suggests, rather, that infants who later develop anorexia nervosa are well cared for but this is done according to the mother's feelings and decisions rather than the child's demands.

At the same time Mara Selvini-Palazzoli (1974) independently developed a similar conceptualisation of the pathogenesis of anorexia nervosa. Like Bruch, she departed from early psychoanalytic hypotheses of orality and focused on ego deficiencies as being central to the development of the illness.

She postulated that the body is experienced by the anorexic patient as something not belonging to the self and as such needs to be controlled. In Selvini-Palazzoli's words the body is perceived as: *" the maternal object, from which the ego wishes to separate itself at all costs" (Selvini-Palazzoli, 1974; p.90).* In this model mothers of anorexic patients are depicted as rewarding compliance to maternal wishes, being overprotective and also unable to allow separation to the child.

A shift from individual to family oriented treatment for patients with anorexia nervosa is reflected in the work of both Bruch and Selvini-Palazzoli. Bruch (1970; 1971; 1973; 1977; 1983) emphasised the importance of the family's inclusion in the treatment, stating that unless the family was involved, treatment was likely to fail. Similarly, Selvini-Palazzoli (1970; 1974) insisted on the family's involvement in treatment having developed a sense of dissatisfaction about the individual treatment for anorexia nervosa as conducted during the 1960s.

The above accounts stemming from both traditional psychoanalytic and object relations theories represent a series of influential attempts of trying to make sense of what is 'going on ' in families containing an anorexic member with Bruch's and Selvini-Pallazoli's work being of particular significance in both pioneering the inclusion of families in treatment as

well as assuming a process of reciprocal feedback between the child and the mother rather than portraying the child as a passive recipient of familial influences.

The formulation of the above psychoanalytic authors are based upon anecdotal reports of clinical observations rather than systematic investigations. In spite of a fairly widespread acceptance of many of Bruch's ideas the only empirical support for her theory comes from indirect evidence of retrospective studies of childhood care patterns (Calam et al., 1990; Palmer et al., 1988; Russell et al., 1992; Steiger et al., 1989) while the prospective studies of mother-infant relationships needed to sustain the original claims are absent in the literature.

This critique, however, should not be seen as an attempt to disqualify the above speculations which may be of theoretical importance and clinical significance. It aims to serve as a reminder, that most of the above speculations regarding pathogenic processes were derived within the context of psychodynamic treatment. Despite the therapeutic potential of these speculations for the particular patients in treatment, they should not be viewed as providing a causal model of the development of anorexia nervosa that would be applicable universally.

b) Comprehensive descriptions of Anorexia Nervosa families: Family Systems

The most influential formulations regarding families containing an anorexic offspring have come from the field of family therapy. Many of the authors providing a family systems account drew upon the psychodynamic ideas of Bruch and others but also offered an alternative perspective suggesting a circular rather than a linear process with respect to the role of the family in the development and maintenance of the disorder.

In other words, the family and/or certain features of it were seen as the context in which the disorder develops rather than the cause of it. As Eisler has pointed out *"the family is viewed as a complex social system in which the various family features are seen as part of a complex matrix of interacting factors, in which the eating disorder is somehow embedded" (Eisler, 1995)*

A number of authors (Minuchin, 1975; Minuchin et al., 1978; Sevini-Palazzoli, 1970; Sevini-Palazzoli, 1974; Stern et al., 1981; Stierlin & Weber, 1989a; Stierlin & Weber, 1989b) provided clinical accounts of families one of whose members suffered from a psychosomatic syndrome, anorexia nervosa included, suggesting that such families possess particular "interactional qualities" which need to be addressed during treatment. Despite respective differences between the accounts offered by different family therapists there is considerable overlap in that families containing an anorexic offspring are usually depicted as extremely close, with blurred intergenerational boundaries where conflict and disagreement are feared and at all costs avoided.

The most influential family systems accounts where provided by Selvini-Pallazoli's model (1970; 1974; 1978) and Minuchin's typology (Minuchin, 1975; Minuchin et al., 1978) which along with other family systems models will be outlined below.

Selvini Palazzoli and her group in Milan (Selvini- Palazzoli et al., 1980) and her group in Milan reported on the treatment of more than 60 children, most of which were adolescent girls suffering from anorexia nervosa. Selvini-Palazzoli's account shifted from her previous formulations of early mother-daughter relationships as central to the genesis of the illness

towards a systems approach. She argued that anorexia nervosa developed from a pattern of interactions within the family evolving for over at least three generations; once the illness has occurred it is maintained but also maintains a circular pattern of interactions within the family which could be modified by family therapy (Selvini-Palazzoli, 1970; Selvini-Palazzoli et al., 1980).

Selvini-Pallazoli's model emphasises the family's need for a perfect, compliant child which is in turn internalised by the child to form her own self-perception as well as the lack of leadership within the family with a predominant spirit of self-sacrifice. All decisions are made for the sake of someone else and thus not attributable to individual preference and therefore members not accepting responsibility for anything once something has gone wrong. Central to Palazzoli's model is also what she termed *"three-way matrimony"* (1974, p.211) referring to the formation of covert coalitions between family members: mother to her husband and daughter, father to his wife and daughter and child to both her parents. These coalitions lead to the child becoming a go-between for the parents, leaving her no energy to strive towards her own independence. Finally, Selvini-Palazzolli (1974) viewed the development of anorexia nervosa as representing the family's conflict regarding loyalty to the present day family as opposed to that of parents' or grandparents.

The most comprehensive description of families of eating disorder patients has come from the structural family theory of Salvador Minuchin and his co-workers (Minuchin, 1975; Minuchin et al., 1978) at the Philadelphia Child Guidance Clinic. According to their view anorexia nervosa was the prime example of psychosomatic illness and their corresponding model of the "psychosomatic family" which was conceptualised as having three factors:

"First, the child is physiologically vulnerable;... Second the child's family has four

transactional characteristics: enmeshment, overprotectiveness, rigidity and a lack of conflict resolution. Third, the sick child plays an important role in the family's pattern of conflict avoidance; and this role is an important source of reinforcement for his symptoms" (Minuchin et al., 1975, p.1033).

In Minuchin's model, enmeshment refers to an extreme form of proximity between the family members, the interactions of which are characterised by over-involvement with one another, often intruding on one's thoughts and feelings. This may manifest itself by family members interrupting one another, speaking for one another or finishing other member's sentences. This results in a weak definition of the self and poor differentiation of one another. There are weak boundaries between family subsystems which are easily crossed e.g. the child uniting with one parent in criticising the other. In enmeshed families loyalty and protection are viewed as more important than autonomy and self realisation while the extreme togetherness often leads to a lack of privacy.

Over-protectiveness refers to a high degree of concern about the other family members' welfare manifested by both children and parents and not being limited to the sick child or the area of illness. *"In such families, the parents' over-protectiveness retards the children's development of autonomy, competence, and interests or activities outside the safety of the family. The children, in turn, particularly the psychosomatically ill child, feel great responsibility for protecting the family" (Minuchin at al., 1978, p.31).*

Rigidity refers to the families' difficulty in adapting to changing circumstances dictated by external sources (e.g. change of house or occupation) or changes within the family itself (e.g. a teenage child negotiating autonomy and individuation). Rigid families experience

situations requiring change in the usual transactional patterns with great difficulty and are characterised by attempts to maintain the status quo.

Lack of conflict resolution is manifested by either avoidance of all conflicts under the façade of family unity or poor resolution of conflicts taking the form of quarrels that never reach an end and a solution. In both instances negotiation doesn't take place and conflicts remain unresolved.

As noted earlier in this section Minuchin et al's (1975; 1978) model has three factors the first being a physiologically vulnerable child, the second referring to the transactional characteristics of the family discussed above and the third involving the child's role in conflict avoidance between the parents also serving as a reinforcer for the anorexic symptom.

Unlike the transactional characteristics which imply a causal relationship between a specific type of family interaction and the development and maintenance of anorexia nervosa this third factor operates at a more complex level involving a multi-dimensional process. Minuchin et al (1978) identified three patterns of the child's involvement as being related to the development and maintenance of psychosomatic illness. In the first two patterns, referred to as "triangulation" and "parent-child coalition", a split is assumed to exist between the parental dyad and a pressure on the child to create an alliance with one parent against the other.

In the instance of triangulation the child finds self-expression impossible without taking the side of one parent against the other; there is no fixed pattern though and the child can be

siding with both parents in an interchangeable way. This is in contrast with the parent-child coalition where the child moves towards a stable pattern of siding with one parent against the other. The third pattern of involvement, referred to as "detouring", assumes an apparently united parental sub-system thought to submerge their conflicts either to protect or to blame their sick child. In that instance the child and his/her illness are viewed as the only problems while in essence being what is keeping the parental dyad together.

At this point it is worth mentioning some features of conceptual overlap between Minuchin's and Selvini-Pallazoli's models. For instance, Minuchin et al's notion of over-protectiveness resembles Selvini-Palazzoli's views of self-sacrifice and lack of leadership and responsibility for consequences of individual actions, while lack of conflict resolution was also emphasised by Palazzoli as an important feature in families with anorexic patients. Similarly, Minuchin et al's processes of triangulation and parent-child coalition bear apparent similarities to Palazzoli's earlier notion of the child assuming a mediating role in parental conflict.

The family systems models developed by Selvini-Palazzoli and Minuchin and his colleagues have given rise to the development of further yet similar ideas by later family therapists. Stierlin and his colleagues for instance put forward a model thought to be applicable to psychosomatic disorders in general (Stierlin, 1981; Stierlin, 1983) proposing three different levels at which a child can be bound to parents interfering with processes of individuation. The first level is characterised by the child's reliance upon parents for gratification of the most primitive needs and this level is characterised by lack of any movement towards separation. At the second level, the child remains bound to the parents as a result of cognitive confusion; having been told how much she is loved and appreciated

by her parents cannot recognise and reconcile any rejecting, hostile or ambivalent behaviour on behalf of the parents, while at the third level the factor mediating staying bound to the parents is guilt associated with transferring of affection from the family to peers and resulting from the exploitation of the child's loyalty to the family.

Loyalty to the family at the expense of fulfilling one's individual needs has also been emphasised by Stierlin & Weber (1989) while for Stern and colleagues (1981) in anorexic families both the child and her parents cannot go through the developmental stage of the child's individuation and corresponding separation from the family and strive towards the prevention of separation taking place.

It is evident at this point that despite their respective differences, most family systems models assume a dynamic and interactive process between family members which combined with societal, life stage and other influences pave the way for the development of anorexia nervosa.

2.2) FAMILIES IN THE TREATMENT OF ANOREXIA NERVOSA

a) Is family therapy effective in the treatment of adolescent anorexia nervosa?

It is interesting to note the relationship between the emergence of theoretical formulations regarding causal factors for the development of anorexia nervosa and the emergence and adoption of corresponding treatment approaches.

From what has been discussed so far it appears that the family's role has for long been a major issue governing the relevant theoretical formulations while, depending on the ever changing ideas, families have been either locked out or brought into the therapy room.

Starting from Gull's, Laseque's and Charcot's parentectomy thought to have a therapeutic function moving to the early psychodynamic therapists who also tended not to include families in the treatment through to object relations therapists (e.g. Bruch) who brought families into the therapy aiming to address the early dysfunctional patterns of mother daughter relations to family therapists also including the families in the treatment aiming to correct the dysfunctional patterns of family interactions thought to have played a major part in the development of the illness in the first place.

However, the above mentioned changing trends in treatment approaches for anorexia nervosa have not always been backed up by relevant evidence. The aim of this section is to examine the evidence with respect to the effectiveness of involving the family in the treatment of an eating disorder and more specifically anorexia nervosa.

A number of follow-up studies provide support for the involvement of the family in the treatment of adolescent anorexia nervosa (Dare, 1983; Herscovici & Bay, 1996; Meyer, 1994; Minuchin, 1975; Minuchin et al., 1978; Stierlin & Weber, 1987; Stierlin et al., 1989b). Although these studies used similar methodological designs and were conducted upon similar populations, other problems stand in the way of drawing clear conclusions.

In the Minuchin et al (1978) and Herscovici and Bay (1996) studies family therapy was not the only treatment as some patients also received inpatient and/or individual treatment, constituting a possible confounder of outcome. In the Dare (1983) and Meyer (1994) studies, where family therapy was the sole treatment modality, the small sample sizes of 12 and 11 patients respectively seriously diminish the power of the results.

The Stierlin & Weber (1987;1989)study used a larger sample (n=42) and family therapy was the only treatment involved. However, both adolescent and adult patients, with longer mean illness duration were included; almost all patients had previous treatment with just over half of them having been inpatients. This makes comparisons with the other studies again problematic.

Nevertheless, the recovery rates reported from these studies of family therapy stand out as particularly good especially when compared with earlier accounts of treatment outcome in adolescent anorexia nervosa, in which the families were not included in the treatment process (Blitzer et al., 1961; Goetz et al., 1977; Lesser et al., 1960; Waren, 1968).

The above studies have methodological problems of the sort that are often encountered in outcome studies such as different definitions of outcome, across study variability of follow-up period as well as different lengths of treatment. The main problem though is the lack of comparison between family therapy and a control treatment modality.

The strongest support for the role of family therapy with this population comes from Randomised Control Trial (RCT) methodology studies where family based interventions are compared with control treatments following in-patient treatment (Eisler et al., 1997; Russell et al., 1987) or on a purely out-patient basis (Eisler et al., 2000; Le Grange et al., 1992; Eisler et al., 2003; Dare et al., 2001).

Russell et al (1987) compared family therapy with individual supportive psychotherapy showing that adolescent patients with a short illness duration fared significantly better in

family therapy with this effect being also detected at the 5-year follow-up (Eisler et al., 1997).

LeGrange et al (1992) and Eisler et al (2000) compared the customary conjoint family therapy (CFT) with separated family therapy (SFT) in which offspring and parents were seen separately; both interventions focus on parents taking a proactive approach towards managing their child's eating behaviour while family and individual issues are addressed at later stages of the treatment. End of treatment results in both studies indicated that both treatments were comparably effective with good recovery rates also evident from the preliminary results of a 5-year follow-up of the latter study (Eisler et al., 1997).

Similarly, Robin and co-workers (Robin et al., 1995) compared a conjoint family intervention termed behavioural family systems therapy (BFST) with an individual therapy (ego oriented individual therapy-EOIT) combined with fortnightly counselling of the parents. The authors point out the similarities of their conjoint intervention with that of the LeGrange et al (1992) study as well as the difference between the two comparison treatments as EOIT encouraged parents to be supportive rather than controlling towards their daughter's eating behaviour. The results indicated that BFST was associated with significantly better outcome in terms of weight gain and menstrual status than EOIT at the end of the treatment as well as at follow-up.

Two other controlled studies of family therapy in anorexia nervosa include adolescent patients but are difficult to compare with the above studies because they also included adult patients and the results are not reported separately for the different age groups (Crisp et al., 1991; Hall & Crisp, 1987). In a further study comparing family therapy with family group

psycho-education (Geist et al., 2000) no differences were found between the two interventions the effects of which though are difficult to evaluate as half of the interventions were part of in-patient treatment while most weight gain (76%) occurred before the patients' discharge.

Support for the usefulness of family interventions in anorexia nervosa also comes from recent studies of Multiple-Family Therapy (MFT). Scholz & Asen (2001) report preliminary results of 37 eating disordered adolescents and their families who attended an intensive MFT day hospital in Dresden, follow-up data is available for 28 families with only one family dropping out and eventually relapsing. Also, most parents and adolescents assessed by the Subjective Family Picture Test (Mattejat & Scholz, 1994) pre and post treatment were found to feel closer to one another following the MFT (Scholz & Asen, 2001).

The clinical account of a similar program run at the Maudsley Hospital, London is described by Dare and Eisler (Dare & Eisler, 2000) (n=14) indicating that MFT has been helpful regarding symptomatic improvement while family tension has been significantly reduced. Both the London and Dresden groups report a reduction in rates of hospital admissions (Eisler et al., 2003).

The above line of research consistently indicates that the inclusion of the family in the treatment has beneficial effects in terms of recovery and this is irrespective of whether offspring and parents are seen separately or conjointly (LeGrange et al., 1992; Eisler et al., 2000). Family interventions focusing on parents adopting a strong proactive role towards managing their daughter's eating are more effective than those promoting support and

cooperation (LeGrange et al., 1992; Robin et al., 1995; Eisler et al., 2000). Also, not involving the family at all can significantly hinder and/or delay recovery in adolescent anorexia nervosa (Russell et al., 1987; Eisler et al., 1997). As for the MFT approaches although sample sizes are small and the results preliminary they seem to be holding some promise.

While the evidence for the efficacy of family therapy in adolescent anorexia nervosa is compelling, relatively little is known regarding factors affecting responsiveness to family based interventions and how these relate to outcome. A further issue involves the "effective ingredients" of family interventions which still remain unclear as well as the mechanisms and processes involved and their corresponding influence on outcome.

b) Is family therapy treating family dysfunction?

As noted in the above section family interventions are useful in the treatment of anorexia nervosa. The pioneers in family therapy (e.g. Minuchin; Selvini- Palazzoli) included the families of anorexic patients in the treatment on the grounds of their conceptualization that families played a pivotal role in the genesis of the illness and that a change in the dysfunctional patterns of family interactions would bring forward a change in the patient's symptoms.

Despite the valuable and insightful observations of the Milan and Philadelphia Clinics as well as those of later authors they have provided us with very little in terms of empirical findings regarding the assumed family dysfunction upon which family therapy is thought to operate. In this section relevant evidence will be reviewed aiming to address the issue of

dysfunction within anorexia nervosa families in terms of whether it exists in the first place and if it can be thought to play a role in the genesis of the illness.

One could argue that the main assumptions of the clinically persuasive models stemming from family systems are firstly that families containing an anorexic offspring conform to a particular stereotype and secondly that these families systematically differ from control families.

Early studies using self-report methodology and in particular the Family Environment Scale (FES- Moos R & Moos, 1981) (Johnson & Flach, 1985; Shisslak et al., 1990; Stern et al., 1981) , the Family Assessment Device (FAD- Epstein et al., 1978; Epstein et al., 1983) (Steiger et al., 1991; Waller et al., 1989) and the Family Adaptability and Cohesion Evaluation Scale questionnaire (FACES-Olson et al., 1979) (Humphrey, 1986; Waller et al., 1990) provide some support for the above hypotheses.

More recent studies however, failed to reveal significant differences between healthy control and anorexic families as most of them tended to score within the normal range of family functioning (Casper & Troiani, 2001; Laporte et al., 2001). Similarly, Waller and colleagues (Waller et al., 1990) indicated no linear relationship between perceived family interaction and scores on eating disorders psychopathology.

Furthermore, when similar research designs were employed using college or community based samples (Blouin et al., 1990; Kent & Clopton, 1992; McNamara & Loveman, 1990; Rastam & Gillberg, 1991) the results failed to reveal significant differences between the functioning of families with or without an eating disordered patient. Also, the scores of

eating disordered families in the FACES tended to consistently fall in the mid-range category, indicating thus normal family functioning (Dare et al., 1994; Le Grange, 1989). In some studies using a mixed design (observation and self report assessment of family functioning) families containing an anorexic child function less well than controls according to observational ratings but this difference is not found in the self-report data (North et al., 1995; Blair et al., 1995).

Finally, in a purely observational study by Roijen (Roijen, 1993) the Beaver's (Beavers et al., 1985) scales were used to rate family interaction. He identified a disorganised (centrifugal), a mixed well-functioning and an enmeshed (centripetal) style of interaction indicating thus within group variability. Furthermore, only four of the eighteen families were rated as moderately or severely dysfunctional and three of those were in the centrifugal group and only one in the centripetal group as would be predicted by Minuchin's concept of the psychosomatic family.

The line of research reviewed above aimed at the identification of the putative characteristics of families containing an anorexic member along the lines of conceptualisation introduced by family systems theorists (e.g. Minuchin, Selvini-Pallazzoli). There have been a number of other studies into the familial influences on eating disorders, which depart from the original family systems models but they have also produced equivocal results.

Several recent studies indicated that attachment processes are abnormal in eating disordered patients with insecure attachments being more prevalent within this group (Ward et al., 2000a, b). The authors nevertheless concluded that such characteristics may be secondary

to the presence of illness in the family rather than of a causative nature (Ward et al., 2000b).

Patients with eating disorders also tend to describe a critical family environment with coercive parental control (Haworth-Hoepner, 2000), while perceived low family communication, parental caring and parental expectations have been suggested as constituting a risk factor for the development of eating disorders among adolescents (Haudek et al., 1999; Neumark-Sztainer et al., 2000). Other studies have shown that mothers of eating disordered patients tend to be more dissatisfied with the general functioning of the family compared to mothers of non eating disordered girls (Hill & Franklin, 1998; Pike & Rodin, 1991).

These findings, however, need to be considered with extreme caution as methodological problems, prevalent in the majority of research looking at the influence of the family in the development and maintenance of eating disorders, stand in the way of drawing clear conclusions. As Polivy and Herman point out in a recent review: *"most studies of family function are predictably, correlational, making it difficult to determine whether family dysfunction contributes to eating disorders, eating disorders contribute to family dysfunction, or some common factor contributes to both. Moreover, the role of the family is often ascertained by retrospective questioning, further undermining our certainty about what caused what".(Polivy & Herman, 2002; p.200)*

In an attempt to address the issue of retrospective questioning while looking at the childhood and family background of eating disordered patients compared with patients suffering from major depression and a non-morbid control group Palmer and colleagues

(Palmer et al., 1988; Webster & Palmer, 2000) employed the Childhood Experience of Care and Abuse Interview. This is a retrospective semi-structured interview assessing care before the age of 17 years and is designed to minimise retrospective distortion; the instrument has the 5 following core scales: *parental indifference; antipathy; parental control; discord in the family; physical abuse.* The results of the study indicated that when compared with the control group the participants with anorexia nervosa did not show significant differences in any of the variables studied while women with bulimia reported significantly more indifference, discord, lack of care and overall adversity than the control group (Palmer et al., 1988)

Although the consideration of differences in how anorexic and bulimic patients view and/or recall their families go beyond the scope of this review some recent findings, such as the above are of relevance due to their theoretical implications regarding the nature of anorexia nervosa. Studies using the CECA (Webster et al., 2000) as well as previous studies exploring differences between anorexic and bulimic patients (Johnson et al., 1985) consistently indicate that there is a tendency among anorexic patients to report less current and past disturbance of social and family relationships in comparison to those suffering from bulimia nervosa. Families of anorexic patients appeared to be recalled as no more different than those of the control group while those of bulimics were significantly more troubled and exhibited the kind of background that could be expected for a psychiatric disorder.

To account for these discrepant findings Webster & Palmer (2000) speculate on an alternative interpretation: *"...if some of the very characteristics, which are noxious in the family of the anorexic, also lead them either to experience or to report their families as*

lacking in the kind of overt troubles documented by research instruments such as the CECA. Such families might tend, for instance, to avoid or deny overt emotional conflict. An explanation of this sort would be broadly in tune with some clinical observations and theorising about the family background of the disorder" (Webster & Palmer, 2000; p.59).

Nevertheless, the authors acknowledge the highly speculative nature of the above possibility and more parsimoniously conclude that anorexia arises in families that do not seem to be disturbed to an unusual degree.

Overall the evidence for psychopathology within anorexia nervosa families is scarce and discrepant. Most studies fail to find significant differences between families containing an anorexic member and control families while the pattern expected to emerge from family systems models is not empirically supported. These findings seem to suggest that the variability observed within anorexia nervosa families resembles that which could be assumed within the general population.

As to the studies indicating some degree of pathology in the parents of anorexics and/or a certain degree of family dysfunction the obstacles in drawing clear conclusion as to causality should be kept in mind. Firstly, as noted above and as various authors have pointed out (Eisler, 1995; Polivy & Herman, 2002; Webster et al., 2000) in the condition of anorexia the relationship between the illness and family dysfunction is reciprocal, making it impossible to draw a clear distinction between cause and effect. In other words, identifying certain correlates as they emerge from comparisons between eating disordered populations and control groups does not in itself constitute evidence that they are causes of the disorder (Polivy & Herman, 2002). Finally, our current knowledge about anorexia nervosa seems to point to the direction of an illness caused by a multiplicity of factors, all of which are

important but none of which is sufficient in isolation (Polivy & Herman, 2002;). Therefore, the quest for identifying the cause of the illness within the family not only seems to be unfruitful but it also is misleading.

From what has been discussed so far, the idea that family therapy treats the heart of the problem in eating disorders (this being a family dysfunction) is challenged. Family factors may, nevertheless, play an important part in treatment either because the treatment may need to ameliorate the negative effects of the illness on the family or because there may be an interaction between specific family factors and particular treatment which may either hinder or enhance therapeutic effects and the aim of the following section will be to address these issues.

2.3) FAMILIES IN ANOREXIA NERVOSA: addressing the paradox

The evidence regarding the efficacy of family therapy in the treatment of adolescent anorexia nervosa and the role of the family in the development of the illness was reviewed in the two previous sections. The overall picture emerging is a somewhat paradoxical one: Family based interventions, initially developed to treat family dysfunction which was believed to have precipitated and/or caused the illness appear to be effective; however, the theoretical models of the family dysfunction that is meant to play a pivotal role in the illness have not been empirically supported. What are then family interventions treating? Where is their locus operandi to be found? How are the therapeutic effects achieved?

Most research to date has focused on two separate strands, one looking for what caused the disorder ranging from biological factors to familial, cognitive, cultural and social

influences. The results of this line of research usually end up with indicating correlates of the illness which by no means can be automatically assumed to constitute actual causes (Herman & Polivy, 2002). The other strand of research aims to evaluate the effectiveness of existing interventions employing either follow-up or RCT designs. In the case of family interventions and family dysfunction a rather arbitrary intersection between the two strands seems to exist: since family interventions are shown to be useful then the problem should be to be found within the family. Although the evidence for this premise remains equivocal there are recent findings, which without assuming a causal role, address the possible role of families in the recovery from anorexia nervosa.

a) The influence of the family in the outcome of Anorexia Nervosa

An association between home environment and outcome in anorexia nervosa was described in the 1970's with a disturbed relationship between the patient and other family members being a significant predictor of an unfavourable outcome (Morgan & Russell, 1975; Theander, 1970).

There is also the general finding suggesting that family functioning is a significant predictor of outcome in a large cohort of patients treated with family therapy (Hampson & Beavers, 1996b; Hampson & Beavers, 1996a) with more competent and more centripetal families (as defined by the authors' corresponding model of family functioning) doing better in therapy, especially if they had attended at least 6 sessions and formed a good therapeutic alliance.

North et al (North et al.,1997) have shown that in a sample of adolescent anorexia nervosa patients good outcome at one year was associated with good baseline family functioning

both as subjectively reported by patients as well as by more objectively recorded by clinicians. Patients with poor family functioning at baseline also improved but only after two years of treatment.

Castro & Cruz (2000) conducted a similar study with a larger cohort (n=158) of adolescent anorexia nervosa patients exploring the relationship of perceived rearing practices with outcome at 2 years. The patients were following a behavioural program aimed at weight gain and cognitive therapy sessions. Although there was no formal family therapy the parents attended both individual and group sessions to help them understand and deal with the illness. The results of the study indicated that the bad outcome group perceived more rejection and control/overprotection from mother and/or father, as assessed by the "My Memories of Upbringing" instrument, than patients falling in the good outcome group. Also, the scale of rejection from father was found to be a significant, independent predictor of outcome.

The above studies provide important evidence to support our understanding of how familial influences, despite not constituting the cause of the illness, can be of relevance with respect to recovery. Nevertheless, the studies conducted during the 1970s (Morgan et al., 1975; Theander, 1970) are far too general to draw specific conclusions about which factors within a family contribute to the bad and/or good outcome while the Hampson & Beavers (1996a,b) study was conducted upon patients having a range of diagnoses and it is, therefore, unclear whether these findings are equally applicable to an eating disorders population. The North et al (1997) study does not provide information regarding the therapeutic input that the patients had and is thus impossible to speculate about how family functioning might have influenced treatment and/or how treatment might have modified

family functioning. Finally, none of the above studies, including the study by Castro & Cruz (2000) monitor changes in family factors as they occur during treatment.

b)The role of Expressed Emotion

Of relevance at this point is the line of research looking at family functioning with respect to Expressed Emotion (EE). Overall, families containing an anorexic child do not seem to be particularly high in EE as indicated by their low scores on Critical Comments (CC) both when considered on their own (Le Grange et al., 1992; Szmukler et al., 1985; Van Furth et al., 1996) and in comparison to other conditions such as conduct disorder(Dare, 1992; Webster et al., 2000) and schizophrenia (Vaughn & Leff, 1976). Increased levels of EE in families containing an anorexic child are rather associated with a severe and chronic nature of the illness (LeGrange et al., 1992). Nevertheless, EE seems to be an aspect of family functioning which is of particular importance to outcome and response to treatment in anorexic patients.

In a study conducted upon adolescent patients with anorexia nervosa it was shown that high levels of parental Critical Comments (CC) at initial assessment were associated with poor outcome at 6 months. Furthermore, when patients were divided into good and poor outcome groups at 6 months, ratings of hostility and criticism were significantly higher amongst the parents of the poor responders while those of warmth were lower (LeGrange et al., 1992). Other authors have confirmed the association between poor response to treatment and high EE levels at baseline (VanFurth et al., 1996; Eisler et al., 2000) while high EE at baseline has also been found to be associated with dropping-out of treatment (Szmukler, 1985).

Furthermore, Eisler et al (2000) from their RCT study of conjoint and separated family therapy reported significant reductions of CC from the parents to the adolescent as well as between parents, with parents being also warmer to one another by the end of treatment. These changes were comparable across treatments. Baseline CC were also found to interact with type of therapy with patients from initially critical families benefiting more from the separated than the conjoint treatment approach. According to the authors this could possibly be accounted for by evidence (Squire-Dehouck, 1993) suggesting a possible relation between an increase in feelings of quilt and blame due to confrontations and criticisms taking place in the context of conjoint family therapy.

Overall, the research cited so far in this section not only demonstrates the importance of family factors in outcome and responsiveness to treatment but also, as illustrated by the relevant EE evidence, family factors change during treatment. Further research is needed however, in order to explore the mechanisms by which family factors affect outcome while changes in family factors during treatment need to be addressed in a more global perspective that will go beyond the EE construct.

Pursuing this line of research has a two fold purpose. Firstly it is of clinical significance as it will generate more information facilitating the better targeting of specific treatments to populations that are more likely to benefit from them. Similarly, clinicians will be more able to modify treatments in order to address areas of family life and/or family relationships which are important to outcome. The second purpose involves research relevance as findings from process research addressing family factors and outcome will guide future research by generating specific hypotheses to be tested in the next generation of outcome

research as well as look more closely to the family factors of relevance to outcome and explore their possible role as mechanisms of the disorder.

2.4) CONCLUDING REMARKS OF CHAPTER 2

Families of anorexic patients have constituted a central point in theories and treatment approaches from as early as the very first descriptions of the condition through drive and object relations psychodynamic theories to the most comprehensive family systems accounts. In the early years families were excluded from treatment approaches on the grounds of their harmful effect upon the patient with this approach being also maintained by some of the early psychodynamic clinicians. Later psychodynamic (object relations) clinicians as well as family therapists included the families in treatment either to address the early mother-child relationship thought to have caused the disorder or, in the case of family therapy, to correct the dysfunctional family dynamics, again thought to have constituted part of the cause of the illness. A series of follow-up and RCT studies in the field have consistently confirmed the usefulness of the inclusion of the family in treatment and the efficacy of family therapy in anorexia nervosa, especially for young patients with a short illness duration. Nevertheless, and despite the effectiveness of family therapy the idea of family dysfunction within anorexia nervosa families is not empirically substantiated with findings from relevant studies remaining equivocal. An alternative speculation has been put forward in this chapter which, drawing by findings of family processes during treatment for anorexia nervosa, suggests that family factors might be of significance in the treatment of anorexia nervosa through a different pathway than that originally speculated by family

therapists (i.e. correcting family dysfunction). In other words, family factors might play a role in family therapy making certain types of therapy more useful for particular families than others while family therapy might be useful through eliminating the negative effect of the illness upon the family rather than correcting family dysfunction. More process research is needed in the field whereby family factors will be systematically addressed as part of follow-up and/or RCT treatment outcome studies to identify changes in those factors as well as corresponding influences upon the patients' outcome.

CHAPTER 3

MULTIPLE FAMILY THERAPY (MFT)

In this chapter the development of the Multiple Family Approach (MFT) will be presented, along with main principles and concepts, starting from the early work of Laquer and his colleagues upon psychotic patients (Laqueur, 1972; 1973; Laqueur et al., 1964;1969) and moving to address further developments of the MFT model as well as its wider applications to the treatment of other conditions. Observations regarding therapeutic processes taking place within the MFT context will be presented while particular emphasis will be given to the application of MFT for the treatment of anorexia nervosa

3.1) DEVELOPMENT OF MFT

Multiple Family Therapy refers to the idea of treating a number of families together and was first described in the literature in the early 1960s in the work of Detre and colleagues and Hes & Handler who described patient- family meetings at the Grace-New Haven Hospital (Detre et al.,1961; Hes & Handler, 1961)

However, it is the work of Laquer and his colleagues that is viewed as pioneering the MFT paradigm, partly for being the first to employ the term but also for having written extensively on aspects, techniques and processes involved in MFT. Laquer and his colleagues developed MFT as a response to the limited hospital resources of the time but yet observed that treating a number of families in the same room could provide a context where different behaviours and new role relationships could be tried out. In Laquer's words *" We soon discovered that the presence of the second, third, fourth or fifth family was not only an*

expedient solution to the shortage of professional personnel, but that this approach had therapeutic advantages as well. For one, it seemed to us that MFT could induce changes in harmful patterns of interaction within a shorter period of time than could the treatment of individual families. [...] when a group includes the members of several families, the therapist is able to use some of the participants in specific co-therapeutic roles to expedite the achievement of insight and the modification of pathological behaviour" (Laquer, 1972; p. 403).

This initial work took place with schizophrenia patients and their families in a hospital ward . The aim of MFT was the improvement of inter and intra family communication in order to help relatives understand some of the patient's challenging behaviours stemming from the idea that problems in relationships come from dysfunctional feedback loops across subsystem boundaries (Laquer, 1972). Despite this being a core premise of Laquer and his group he also employed other theoretical models such as attachment theory and psychodynamic ideas with a central hypothesis being that in normal development, secondary objects of attachment replace primary ones thus the presence of other families facilitated one's struggles towards independence and self-differentiation through the identification of members of other families and learning by analogy (Laquer, 1973).

Many different clinicians were later inspired by Laquer's early work and developed MFT approaches to be used in various settings and different populations. For instance McFarlane (1982) and Anderson (1983) independently developed two different MFT models to be used with schizophrenic patients and their families.

A core component of McFarlane's approach was educating the families about the index patient's illness which, combined with the group approach, facilitated reconciliation, stigma reversal, normalization of communication and crisis management. Similarly, Anderson (1983) developed a psycho-educational approach with multi-family groups, the underlying theoretical assumption of which focused on the importance of the dynamic social process of dialogue and conversation in inferring meaning and understanding. She viewed her approach as helping families and patients with respect to stigma reduction, expansion of their social network, relief of carer burden and reduction of Expressed Emotion in key relatives.

Since the early work of Laquer and his group the MFT paradigm has been further expanded and elaborated (Anderson, 1983; Lansky, 1981; McFarlane, 1982; Strelnick, 1977) while it is now considered a well-established approach in the work with schizophrenia patients (Kuipers et al., 1992) and also employed in various other conditions (O'Shea & Phelps, 1985) including drug and alcohol abuse (Kaufman & Kaufman, 1979), chronic medical illness (Gonsalez et al.,1989), Huntingdon's disease (Murburg et al.,1988), child abuse (Asen et al., 1989), eating disorders (Slagerman & Yager, 1989) and bulimia nervosa (Wooley & Lewis, 1987) as well as a mixture of in and out patient children and adolescents presenting to the services with a variety of problems (Wattie, 1994).

It is interesting at this point to note that MFT models have mainly been used in conjunction with other treatments rather than as the sole treatment modality. With this respect, administering MFT as the main treatment modality with other treatments being used only occasionally was first introduced at the Marlborough Family Service in London in the late 1970s (Asen et al., 1982; Cooklin, 1982; Cooklin et al., 1983) at a unique approach to

MFT for multi-problem families in which more than one member presented with psychiatric and/or antisocial symptoms. MFT was employed here in the context of an intensive day hospital approach for these multi-problem families for whom various other treatments had failed. A similar approach has been recently pioneered in eating disorders patients and their families and will be described in more detail in a later section.

Multiple Family Therapy is a rather peculiar blend of group and family therapy in which other aspects, including psycho-education and family therapy techniques can be incorporated. Furthermore, MFT is not an approach tightly bound to a specific school of thought as most psychosocial interventions are but can be informed by a variety of perspectives which are of relevance to the targeted population. It is perhaps because of this flexibility, inherent in MFT, that various clinicians have used it differently and have modified it according to the practicalities of their services and the needs of their patients. While this is an advantage as far as clinical practice is concerned it poses some drawbacks when it comes to evaluating relevant research. For instance, differences in frequency, techniques employed etc. make comparability between various MFT groups difficult. This limitation also extends to the difficulties in identifying the effective ingredients of MFT which, despite the various speculations, theories, conceptualisations and hypotheses, still remains a challenge.

3.2) MFT AND EATING DISORDERS

In this section work on applying MFT upon eating disorders population will be reviewed with more emphasis on the work conducted in Dresden (Scholz et al., 2001) and in London

(Dare et al., 2000) in applying MFT within a day hospital setting for adolescent anorexia nervosa patients.

Both the Dresden and London projects have been inspired by the Marlborough Model (Asen et al.,2001) and are very similar in terms of treatment context, content and techniques employed.

Preliminary results offered by the London and Dresden groups are encouraging. The Dresden group (Scholz & Asen, 2001) reported follow-up data of 28 eating disordered adolescents treated during an 18 month period. Stabilisation and/or improvement has been noted in 27 of the patients with no serious relapse while the one patient who dropped-out of the MFT treatment had reached her target weight but suffered a subsequent relapse.
A consumer satisfaction survey indicated that 93% of parents, 84% of patients and 100% of staff were in favour of a combination of inpatient and multiple-family day treatment while 100% of parents and 80 % of patients viewed working together with other families in a day hospital setting as being helpful as well as desirable.

The Dresden group also reported on pre and post MFT treatment changes in the Subjective Family Picture Test (Mattejat & Scholz, 1994) which is a validated measure of the patient's and the family's subjective views of the other family members in relation to a number of different dimensions. The authors commented on these findings as being rather unexpected as despite the intensive conflicts that emerged during the multi-family work the emotional closeness between family members did not decrease during and after therapy. In most families both patients and parents reported feeling more emotionally close to one another than prior to the therapy. Also, the individual autonomy and independence of the parents

was significantly increased post treatment and this was the case as seen from both the parents' and the patient's perspective.

The London group (Dare & Eisler, 2000) has also offered preliminary pilot results of 14 adolescents treated with MFT half of whom suffered from anorexia nervosa and the other half from bulimia nervosa. None of the patients had to be subsequently admitted into an inpatient service and the preliminary results suggest that the program may be beneficial in terms of symptomatic outcome as all the patients showed some improvement in terms of increased weight, return of menstruation, stabilization of eating, reduction of bingeing/vomiting and laxative abuse. None of the patients dropped out of treatment while parental attendance was good with most parents being present for the majority of the MFT program. The authors noted that family tension and dispute had been reduced during the course of the treatment creating thus a cooperative and supportive atmosphere for the patients. Furthermore, the authors reported that in comparison to the families' and patients' responses to the customary single family treatments offered at the service the families have been considerably more enthusiastic about the MFT program.

Needless to say, the results reported by both the London and Dresden groups are only preliminary while the small numbers, brief follow-up period and the lack of a comparison group do not permit for any conclusions regarding the treatments' efficacy. Nevertheless, these results can be seen as promising, especially if the severity of the patients' illness is taken into account; all patients in the Dresden group were inpatients at the time of joining the program while most of London patients have been inpatients in the past and/or have been referred to the service for an inpatient admission.

3.3) THERAPEUTIC POTENTIALS OF MFT

The various clinicians employing the MFT paradigm upon their patient populations, have provided us with quite significant thoughts, reflections and observations. In this section an overview of the main mechanisms thought to operate within the MFT context and thus produce therapeutic change will be presented. More emphasis will be put on those processes observed by clinicians in their work with eating disordered patients.

It is not surprising that Laquer's (1972) observations regarding processes of change during MFT (summarised in the table 3 below) have provided us with a very comprehensive account of possible therapeutic factors encountered within this treatment setting. In an overall sense, these suggest that patients and families gain important insights by observing each other and learning from each other. Underlying this is the common problem and the similar struggles and challenges faced by members of the MFT group. The MFT setting also provides an environment where different behaviours and role relationships can be tried out and the mutual support between the families is of core importance.

Table 3. Laquer's account of therapeutic processes in MFT
➢ The use of the family as a co-therapist ➢ Competition among families ➢ Learning by analogy ➢ Learning through identification ➢ Learning through identification constellation ➢ Tuning in ➢ Learning through trial and error ➢ Use of models ➢ Focus on excitation ➢ Amplification and modulation of signals

Further accounts regarding therapeutic factors of MFT have been suggested by other clinicians. These include the establishment of a community with shared experiences (Steinglass, 1998), overcoming stigmatization (Asen et al., 2001), the generation of new and multiple perspectives regarding both the illness and the family (Asen, 2002; Bishop et al., 2002; Steinglass, 1998); peer confrontation (Leichter & Schulman, 1974); trying out new adapting patterns of coping and relating (O'Shea et al., 1985; Strelnick, 1977) and experiencing hope and progress (Laqueur, 1973).

Of particular relevance are the therapeutic processes observed by the groups who have been influenced by the Marlborough model and employed MFT for the treatment of adolescent eating disordered patients.

Both the London (Dare & Eisler, 2000) and Dresden teams (Scholz & Asen, 2001; Asen,2000) have at various instances presented detailed observations and relevant accounts of why the MFT paradigm is useful in the treatment of adolescent eating disorders. The employment of MFT by both teams is influenced by the original Marlborough Model (Asen et al., 1982; Asen et al., 2001; Cooklin et al., 1983; Morgan et al., 1975) while the main aim, in line with the Maudsley model of family therapy for adolescent anorexia nervosa, remains to assist families in rediscovering their resources which are possibly compromised by the illness, while taking an active role in their child's recovery.

Both teams have noted the complex set of feelings experienced by those families including, guild, blame, fear anger and embarrassment as well as the isolation the illness has brought upon the family. In that instance bringing these families together allows for these to be shared and addressed while a sense of solidarity is quickly developed also reducing the

stigma experienced by the families. Further to that, the authors of both groups comment on the effect of the presence of other families in highlighting similarities as well as differences between them allowing thus new and multiple perspectives to emerge on ways of dealing and coping with the illness.

Directly observing how all families differ also facilitates parents and patients alike to realize that there is no specific family constellation and/or dynamic responsible for the development of an eating disorder with this having a direct effect in reducing the parents' sense of guild. Furthermore, and as Asen (2002) postulated in the MFT setting families rather than medical staff are in the majority with this contributing to the development of a family rather than a medical atmosphere. As a result each family becomes less central while the feeling of being constantly watched by staff diminishes. Also, both teams identify benefits in directly involving the parents in their child's feeding and food related issues as this assists them to become expert themselves rather than perceive the expertise as an attribute of medical staff only.

Another aspect of the MFT context as described by Asen (2002) is peer support and criticism. In that instance, and contrary to customary family therapy where this takes place between the family and the therapist, in MFT support and criticism occurs between the families. Given that all these families have painful direct experiences of their child's illness they perceive the feedback offered by fellow-parents as more credible than that offered by staff. Along these lines, Asen comments on the role of the therapist in the MFT setting.

"the role of the therapist is that of a catalyst enabling families to connect with one another and encouraging mutual curiosity and feedback." (Asen, 2002; Webster et al., 2000)

All of the above therapeutic potentials constitute important clinical markers for clinicians wanting to employ MFT paradigms in their own practices. Nevertheless, despite their informative value they remain impressionistic accounts of perceived therapeutic processes while there is preciously little systematic investigation on the process of change in MFT.

3.4) CONCLUDING REMARKS OF CHAPTER 3

The MFT approach has been further expanded and elaborated since the early work of Laquer and his colleagues possibly due to the various imaginative and daring clinicians keen to implement this treatment and modify it so as to suit the needs of their patients. By now MFT has been used in a variety of ways for the treatment of different patient populations; the feedback coming from relevant researchers and clinicians points to the direction of a possibly effective treatment. However, there is a lack of systematic outcome research in the area calling for studies testing its effectiveness for the various conditions. A further challenge, prevalent in family based interventions, involves the identification of therapeutic factors of MFT as despite the meaningful observations described earlier in the chapter, the relevant accounts of therapeutic process remain highly speculative.

CHAPTER 4

THE PATIENTS' AND FAMILIES' PERSPECTIVE

In this section the importance for the patients' and families' perspective regarding the treatment they receive will be examined with particular emphasis on family interventions for adolescent anorexia nervosa patients. Evidence on patient satisfaction of eating disordered patients with treatment will be critically reviewed with a focus on the adequacy of the methodology employed so far. Furthermore, an alternative approach, that is enquiring about helpful/unhelpful events during therapy, of gaining insight into patients' and families' treatment experience will be reviewed along with relevant evidence from family based interventions. Implications for process research will be discussed.

4.1) THE PATIENTS' & FAMILIES' PERSPECTIVE: why is it important?

The most obvious reason for looking into the user's perspective with respect to a psychosocial intervention is to enable clinicians to develop and deliver treatments that are sensitive to the needs of the targeted patient population as well as acceptable on behalf of the patients/families undergoing those treatments. A further, less obvious but no less important reason for looking in detail into the patients'/families treatment experience is the need for more process research into the effective ingredients of our interventions.

A significant improvement in psychotherapy research has been the employment of Randomised Control Trial (RCT) methodology aimed at comparisons between different interventions for a given disorder. In turn, treatment manuals have been developed putting emphasis of specifying treatment components (Oei & Shuttlewood, 1997). In other words,

the focus is not only on which treatment is more effective for a given disorder but also on the identification of the therapeutic ingredients of the intervention

A further relevant advance in psychotherapy efficacy research over the past three decades has been the distinction between "unique" and "common" factors in psychotherapy as well as their contribution to outcome (Chatoor & Krupnick, 2001). "Common" or "non-specific factors" refer to dimensions that are shared by most psychotherapies including treatment alliance, therapists' competence as well as adherence to treatment manuals. "Unique" or "specific factors" refer to the specific techniques and interventions that are characteristic of particular interventions".

With respect to adolescent anorexia nervosa and as noted in Chapter 2 the evidence suggests that involving the family warrants significant benefits for these younger patients with a short illness duration while the original speculations of what is modified through family therapy (i.e. family dysfunction being the cause of the illness) are not empirically sustained leaving us thus with little information regarding what makes this type of intervention effective in adolescent eating disorder. Similarly, with reference to Multiple Family Therapy as reviewed in the previous chapter there are plenty of speculations regarding the possible therapeutic mechanisms to be found in not only involving the family but also treating a number of families together and the possibility of therapeutic group effects. Still, we know preciously little regarding how this treatment approach is perceived by patients and families and whether the speculated therapeutic potentials are perceived as helpful and or unhelpful as well as their potential relationship to outcome.

In other words, exploring the patients' and families' perspective has a two-fold purpose. Firstly, it will enable us to have a clearer understanding regarding the acceptability of the treatment to those involved; secondly it will contribute to process research of this treatment modality throwing some light into potential mechanisms and interventions that make the treatment effective.

At this point though, it worth mentioning that by the term treatment experience one refers to a very broad concept encompassing a range of complex beliefs, cognitions, subjective experiences and meanings attached to them. With this respect patient satisfaction and accounts of helpful events are of significance to the present study. The relevant research evidence will be reviewed and the methodology discussed in the two following sections.

4.2) PATIENT SATISFACTION

The perspective of those involved in any treatment is a very relevant issue to be addressed, especially with reference to a new therapeutic approach. The most usual way of addressing this issue is through surveys of patient satisfaction. There are a number of reasons why patient satisfaction is important, including its relationship to clinical outcome (Svenson & Hansson, 1994) and the patient's willingness to use services (Priebe & Gruyters, 1995). Similarly, correlations between patient characteristics and satisfaction with care are reported including age, diagnosis, legal status and ethnicity (Leavey et al.,1997; Perrault et al, 1996).

There are only two large scale surveys addressing the issue of satisfaction with care and treatment in eating disorders populations; the original study having been conducted in the

U.K (Newton, Robinson, & Hartley, 1993) while its replication was conducted with a Norwegian sample (Rosenvinge & Klusmeier, 2000). In both studies a large cohort of participants was selected from members of two support organisations for current or past eating disorder sufferers.

Overall, results regarding patient satisfaction were similar in both studies with participants reporting high levels of satisfaction with psychotherapy and particularly individual and group treatment as well as self-help activities. However, a marked dissatisfaction was noted in both studies regarding family therapy possibly relating to feelings of blame parents might be experiencing when asked to attend the treatment as a family.

These two studies represent a valuable attempt towards the exploration of the patients' perspective regarding services received within the context of eating disorders. One limitation, however, is that data is not provided regarding subgroups of the patients who participated. No distinctions are made between former and current patients, anorexics and bulimics as well as young patients with a short illness duration as opposed to adults in whom the illness has assumed a chronic course.

The evidence reviewed above clearly demonstrates the importance of client/patient satisfaction as well as its relevance to anorexia nervosa. However, most of the studies Nevertheless, in considering the methodology by which information on patient satisfaction is gathered it is likely that we only get a tiny fracture of the bigger picture. A relevant issue involves the extent to which quantitative ratings, employed in client/patient satisfaction research adequately capture the complex set of beliefs and experiences regarding the services patients and/or families receive. The consistent and almost uniform finding of high patient satisfaction in both mental health (e.g. (Corringhan, 1990)and medical settings (e.g. (Hall et al.,1988; Hall & Dornan, 1988) are indicative of either genuine and strong

satisfaction with health care services or of problematic methodology in addressing the issue.

It is reported that no more than 10% of service users score within the dissatisfied range (Greenfield & Attkisson, 1989; Hall et al., 1988) while even in long term institutional care or in involuntary hospitalisations (e.g. Bene-Cociemba et al.,1982; DiStefano et al.,1983; Elzinga et al., 1991; Plutchik et al., 1978; Spensley et al., 1980) and this is the case irrespective of the care provided, service or setting (Greenfield et al., 1989; Hall et al., 1988; Lebow, 1982). This sort of evidence, complemented by anecdotal reports (e.g.Gill et al.,1998)points in the direction of biased and/or problematic methodology rather than actual high satisfaction.

Uniformity in high ratings may be due to problems in conceptualising and thus assessing patient satisfaction with most research employing standardised questionnaires (e.g. Client Satisfaction Questionnaire –(Attkisson & Zwick, 1983); Verona Service Satisfaction Scale-(Ruggeri & Dall'Agnola, 1993)which despite the good psychometric properties they possess might be less adequate in capturing the richness of associated experiences.

As Williams (Williams, 1994) has pointed out: *"The reductionism necessitated by a quantitative survey may result in diverse opinions ranging from* ***'I've evaluated the service and I'm happy with it'*** *through* ***'I don't think I have the ability to evaluate but I do have confidence in the staff'*** *to* ***'The service was appalling but I don't like to criticise, after all they're doing their best'*** *being collapsed into a single category of users all of whom expressed satisfaction" (Williams, 1994).*

In light of the above, it could be argued that in order to devise a meaningful approach to the user's perspective, the more specific issues of *why* and *how* service users are satisfied should be addressed alongside the general question of *whether* they are satisfied. Also, these should be addressed by taking into account the specific population under investigation as well as the specific services/treatments they receive.

With this respect, the following section on "Helpful Events" will discuss both the existing research and methodology of an alternative, more detailed approach, in exploring patients' and families' treatment experience.

4.3) HELPFUL INSTANCES/EVENTS IN PSYCHOTHERAPY

Most research conducted upon psychological interventions for anorexia nervosa and indeed other disorders ((Llewelyn, 1988a; 1988b; Llewelyn et al.,1988) have mainly focused on the identification of the most effective intervention for a given disorder, usually adopting the quantitative method as the basis for data gathering. However, as Llewelyn (1988a) accurately points out, although this research has been fruitful in many instances, it is very often conducted from within specific theoretical frameworks and the exclusion of subjective data makes it theory-driven while not taking into account alternative ways of construing the therapeutic experience.

Nevertheless, and despite Llewelyn's criticism, efficacy research has been very useful in both the establishment of psychotherapy as a useful way of treating a variety of problems (e.g. Andrews et al ., 1982; Stiles et al., 1986; Lambert et al., 1983; Landman & Dawes, 1982) as well as indicating what sort of treatment is more beneficial for a given patient population.

The advances in efficacy research has given rise to new questions and challenges, one of them being the identification of the useful aspects of an intervention either proven to be effective or being tested for its effectiveness. This has lead to an increased interest in the exploration of helpful/unhelpful events taking place during the process of psychotherapy as perceived by the therapy participants. The main assumption is that such events will convey information regarding the useful aspects and therapeutic potentials of a given intervention, which underlie its effectiveness.

Central to this approach is the fact that, instead of testing specific hypotheses, it is oriented towards "discovery" (Elliot et al.,1985). Similarly, this approach is not intended to draw conclusions regarding the accuracy of the views of participants' but rather to reflect and describe their subjective experience of the helpful and hindering events during the process of psychotherapy and how this may relate to outcome (Llewelyn, 1988a; Llewelyn et al., 1988).

The rest of this section will review research employing this explorative method in order to identify helpful factors encountered in psychosocial interventions for a variety of presenting conditions. More emphasis will be given on studies exploring significant helpful events within family based interventions.

The identification of helpful and/or unhelpful events perceived by patients' as a way of exploring therapeutic factors has been recently used in individual (Elliot, 1986; Llewelyn et al., 1988)and group (e.g. Holroyd & Themen, 1979; Bloch et al., 1979) psychotherapy research. Llewelyn (Llewelyn, 1988a) for instance analysed significant events identified by 40 patients over an average of 10 sessions each, and contrasted them with the events

identified by their therapists. The findings indicated that while therapists, coming from various theoretical backgrounds and using a range of techniques, perceived gaining of insight as the most important helpful impact for their patients, the clients themselves reported the most helpful aspects of therapy to have been reassurance and relief gained, as well as help in solving their problems.

These findings are consistent with those reported by Feifel & Eels (1963) and Strupp and colleagues (1964). Murphy et al., (1984) have also reported similar findings in an exploratory interview study, where the most helpful events in therapy as perceived by clients were advice and talking to someone who understands while Lietaer (1983) also found relational aspects of therapy to have been more important for clients than for therapists.

With respect to the relationship between perceived significant events and outcome Llewelyn et al (1988) indicated that only the prevalence of "unwanted thoughts" attributed to therapy were negatively correlated with outcome while the authors indicated that it is too early to conclude that therapeutic impact, as reported by clients is not related to outcome.

With respect to family based interventions most research has focused on the therapists' and/or research perspective while it is only recently that researchers began to ask family members about their experience of treatment. Kuehl (1986) was the first to enquire about adolescent and adult family members' treatment experience of family therapy as part of a larger study testing the efficacy of family therapy in treating adolescent drug abuse. Without formally testing for it, Kuehl's work challenged what seemed to be therapists' generally accepted views. For instance, although therapists tend to assume that despite

adolescents' initial nervousness with being videotaped they quickly adjust to it, many adolescents said that they continue to be sensitive to the presence of the camera and a lot of them stated that they would purposefully sit so that they would not be seen on camera (Newfield et al., 1990).

A further study, exploring preadolescent children's experience of family therapy indicated that children wanted to be part of therapy sessions (meaning both being physically present as well as being involved in what was going on) while the therapist's personality was a theme of less importance for the children than it was for parents. Overall, the authors in this study concluded that the children wanted to be involved in therapy in a meaningful way (Stith et al.,1996).

In a similar study employing qualitative methodology five children between the ages of 11 and 17 attending two family therapy clinics for a variety of problems were interviewed about their experience of family therapy where children were asked to recall what they perceived as helpful and unhelpful following a family therapy session. Helpful events or moments were then replayed on the videotape of the session in order to assist the child's memory. The results of this study highlighted a diversity of experiences (including being heard, not feeling heard, coping with challenges, bringing back memories, difficulties in saying what you think and feel, concerns about reactions from other family members, need of support in the sessions) according to the child's age, gender and position in the family. The authors suggested that the results of this study have challenged some of the assumptions commonly held by therapists such as for example the idea that some children preferred more directive and focused aspects of therapy as opposed to systemic questions

which could give rise to feelings of confusion and inadequacy (Strickland-Clark et al.,2000).

A further study exploring patients' end families' treatment experience from a family intervention program for psychosis was conducted at the Somerset Partnership NHS Trust "Family Support Service" (Stanbridge et al.,2003). Similarly to the studies reported previously in this section, the authors have employed a qualitative methodology in order to explore family satisfaction and helpful/unhelpful events as perceived by the patients and families who took part in this family intervention. Despite their initial preconceptions of worry and apprehension, patients and families reported high satisfaction with the program while there was very little the families did not like about the intervention. As to the helpful aspects of the intervention the main themes that emerged from the families were the opportunity for open discussion, the development of new perspectives as well as problem-solving skills and the closer working and cooperation with mental health services. Furthermore, qualities of the therapeutic relationship perceived by the families as helpful were highlighted including a non-judgemental and empathic approach as well as mutually agreed goals.

Two studies have looked into the treatment experience of family therapy in adolescent anorexia nervosa. Le Grange and Gelman (1998) conducted a qualitative study upon ten adolescent patients undergoing family therapy for their eating disorder. They suggested that the treatment was acceptable to their patients who nevertheless expressed concerns about a lack of focus on the cause of the illness and a neglect of other personal problems during treatment. A more recent study was conducted by Krautter & Lock (2004) on a relatively large cohort of families. They reported that both parents and patients evaluated the

treatment positively and have found it to be effective. Most of their participants indicated improvements in family closeness and communication while most patients reported feeling less guilty as a result of the family therapy. Although this last study is quite comprehensive in terms of sample size and assessment procedures it involved patients who completed the treatment (or at least 80% of it); therefore, the families who dropped-out, possibly representing those who were more likely to express dissatisfaction have not been enquired. Also, the assessments took place at the end of the treatment; preliminary results reported by the authors indicate that most patients showed significant improvements in their eating disorder by the time of discharge; the positive view of the treatment is thus not surprising as this is likely once the patients have improved (Krautter & Lock, 2004). In other words, this study possess the disadvantage of retrospective questioning a proportion of the families who engaged quite well with treatment so as to complete it with relative success in terms of weight gain.

Of particular relevance is a pilot investigation conducted by Lemmens and colleagues (Lemmens et al., 2003) on the perception of helpful events by both families (n= 10 families) and the therapeutic team in two family discussion groups of a psychiatric day clinic. All participants responded to open ended questions enquiring about helpful events experienced during the family discussion groups at three distinct levels: that of the individual patient, the family and the entire group. The findings of the study indicated that both therapists and participants experienced helpful events during the intervention; nevertheless some of the differences between perceptions of therapists and families were striking. Firstly, it is worth noting that therapists rarely indicated that "no helpful events happened" which was in contrast to the families of whom 25 to 40 per cent indicated that no helpful events happened at one or more levels. Similarly, the results indicated that in an

overall sense families differed from therapists in their perceptions regarding which factors of the family discussion groups were important. More specifically the therapeutic team perceived the structural aspects of the group, including support and group involvement, as more helpful than the families. On the other hand, families found the process aspects of the group, including gaining insight and the experience of communality more salient in terms of helpfulness than did the therapeutic team.

The above line of research can be seen as an important contribution in a variety of ways. Firstly, it addresses the under-researched issue of patients' and families' perspective by employing an imaginative and fruitful approach which departs from the customary client satisfaction surveys based on questionnaires which indeed can only reach a limited level of information (Alexander et al.,1994; MazKenzie, 1987).

A further contribution of research into experience of helpful events involves both the clinical and the theoretical level. At the clinical level, the line of research cited above provided clinicians with important insights regarding the users' treatment experience from a variety of interventions with this having important implications in both engaging patients and their families in treatment as well as some information about ameliorating treatments based on what the users find helpful. This is not, however, to say that processes not mentioned by the patients/families are of no relevance to therapeutic outcome. As Lemmens et al (2003) acknowledge, the open ended methodology provides access to the therapeutic processes that operate at a conscious level and/or are salient enough for the patients'/families to mention them.

Exploring patients'/families' perceived helpful events bears a significant contribution at a theory level in that it throws some light on the possible therapeutic ingredients of a given intervention which are usually speculated upon but rarely tested and enquired about.

The perception of helpful/unhelpful factors remains an under-researched area, which is perhaps symptomatic of the methodological problems, which makes drawing conclusions difficult. For instance sample sizes in most studies were small and participants in each study suffering from a variety of psychological problems and disorders not clearly specified. Similarly, no detailed descriptions and/or manuals regarding the specific interventions given were available by the authors of the above studies. Future research should be more targeted in that respect so as to explore the treatment experience of patients'/families' of carefully selected patient population groups. Similarly the relevant insight obtained should be linked with the treatment potentials and speculated therapeutic factors of the particular intervention administered.

4.4) CONCLUDING REMARKS OF CHAPTER 4

Addressing the perspective of those involved has been indicated in this chapter as an important issue for any psychotherapeutic approach and with particular relevance to family interventions for adolescent anorexia nervosa. This is in respect to the amelioration of our treatments and techniques as well as the respective contribution to process research. However, the customarily used patient satisfaction method, although revealing, has important shortcomings in exploring the complexity of psychotherapy's experience. It is suggested that including a qualitative element to the study of patient experiences of

treatment provides a more in depth approach that will allow the exploration of the treatment process alongside the general question of users' satisfaction.

CHAPTER 5

OVERVIEW OF METHODOLOGY AND THEORETICAL RATIONALE OF THE STUDY

5.1) QUANTITATIVE METHODOLOGY? QUALITATIVE METHODOLOGY? OR BOTH?

The fundamental debate between quantitative and qualitative methods of enquiry can be traced back to a disruption that took place in the 18th century regarding the basic question as to how one pursues the discovery of truth. The most notable works that indeed shaped much of modern western thought where the writings of Rene DesCartes's (1596-1650) and Immanuel Kant's (1724-1804).

DesCartes founded the field of quantitative research in his work *"Discourse on Method"* (1937, 1968) where he postulated the need of natural philosophy to be refocused around the "certainty and self-evidence" of mathematics (DesCartes,1968, p.31) while he proclaimed the need for objectivity suggesting that in order for the truth to be discovered researchers have to stand back from the elements in the world that might corrupt their analytic powers.

Kant on the other hand, in his effort to resolve the conflicts between the Cartesians and the skeptics provided with possibly the most significant post-Cartesian intervention. In the *"Critique of Pure Reason"* (1781) he laid the foundation of qualitative thinking. As Hamilton puts it: *"Kant proposed, in effect, that perception is more than seeing. Human perception derives not only from the evidence of the senses but also from the mental apparatus that serves to organize the in-coming sense impressions. [...] Human knowledgeis ultimately based on understanding, an intellectual state that is more than just*

a consequence of experience. Thus, for Kant, human claims about nature can not be independent of inside the head processes of the knowing subject" (Hamilton, 1994; p.63).

The distinction between quantity and quality, as it emerged in the 18th century is by now evident with DesCartes putting forward an epistemology focusing around objectivity and mathematics and Kant suggesting an epistemology transcending the limits of empirical inquiry while taking into account the investigator and allowing in-side the head processes such as understanding and interpretation. Further to that though, Kant being influenced by the works of Aristotle and Machiavelli drew a further important distinction: that between *"scientific"* and *"practical"* reason (Ermath, 1978) postulating that the world of nature as described by science is one of strict causal determinism while the world of moral freedom is *"governed by autonomous principles which man prescribes to himself" (Ermath, 1978; p.42).*

The distinction between quantitative and qualitative methodologies in modern science is somewhat more similar to DesCartes's and Kant's early postulations than one would expect, given the centuries in between.

Qualitative methods involve a number of diverse approaches with differing epistemological assumptions and philosophical bases. The one thing however they share in common is an emphasis on the enrichment and understanding of the phenomena under study rather than the verification of earlier conclusions and theories, the testing of hypothesized relations and causal explanations and/or the assessment of generalizability across samples which has primarily been the focus of quantitative research (Elliot et al.,1999). Furthermore, and

despite the different approaches of qualitative enquiry Stiles (Stiles, 1993) has indicated the following as the basic tenets and preferences of this strand of research:

- A preference for **linguistic results**: results are presented and elaborated in words rather than in numbers which are believed to impoverish human experience
- The employment of **empathy as an observation strategy**: qualitative researchers are not assumed to be independent objective agents. Instead, by drawing upon and acknowledging their own background and experience as well as the societal context, they engage in a process of understanding with respect to the participant's meaning(s) and subjective experience.
- A preference for **contextual interpretation**: understanding takes place within the setting in which the research activity takes place as well as within the context of both the participants' and researchers' personal histories and cultural context.
- An emphasis on the **polydimensionality of experience**: variability in experience is embraced and favoured by qualitative research; instead of limiting experience in a few dimensions polyphony and variation are preserved.
- A preference **for non-linear causality**: non-linear causality is accommodated in qualitative methods and thus research aims emerge alongside the methods rather than having pre-determined objectives.

Historically, there has been a heavy emphasis on the degree of quantification in the various sciences with scientific maturity being almost synonymous to the degree of quantification found within a given field. Cuba and Lincoln refer to this tendency as the "received view

of science" and describe it as follows: *"positivism, transformed over the course of this century into post-positivism, focuses on efforts to verify (positivism) or falsify (post-positivism) a priory hypotheses, most usefully stated as mathematical (quantitative) propositions or propositions that can be easily converted into precise mathematical formulas expressing functional relationships. Formulaic precision has enormous utility when the aim of science is the prediction and control of natural phenomena. Further there is already available a powerful array of statistical and mathematical models."(Cuba & Lincoln, 1994; p.106).*

At this point it worth mentioning that quantitative methodologies have their roots in the natural sciences, such as physics and qualitative methods have come from the social sciences such as sociology and anthropology; thus, with reference to psychological investigation none of the methods has evolved for the field and within the field. It is rather the case that both quantitative and qualitative methods have been taken of their original contexts of development and adopted by investigators to address the variety of issues addressed by psychological enquiry. Psychological research, similarly to clinical biomedical research have for long been governed by strictly empirical approaches ignoring the scope and space for qualitative work and critical conversation. Nevertheless, calls have begun over the recent years highlighting the need for a greater methodological diversity and also including the employment of qualitative work (Freymann, 1989; McWhinney, 1986; McWhinney, 1989; Waitzkin, 1991).

Overall, as Elliot (1999) puts it the scientific questions addressed by qualitative research differs from those examined by quantitative research and therefore the selection of one method over the other or indeed the combination of both methods should be guided by the

method's ability to provide meaningful and sensible answers to the specific issues and questions that have stimulated the specific piece of research in the first instance. In other words one should be guided by the questions under investigation in evaluating the appropriateness of each method rather that limit the subject of inquiry due to his/her preconceptions of what constitutes an appropriate method.

5.2) THEORETICAL BACKGROUND OF THE PRESENT STUDY

As demonstrated in Chapter 2, by now there is ample and consistent evidence for the involvement of the family in the treatment of adolescent anorexia nervosa while the exclusion of the family, so prevalent in early treatment approaches, appears to compromise these young patients' outcome. It was possibly the successes as well as the difficulties encountered in treating families with an anorexic member using the customary family therapy that lead to the application of MFT approach upon eating disordered patients. This was possibly in the hope that therapeutic effects of family therapy will be further enhanced by the presence of other families struggling with similar problems.

Despite the evidence for the usefulness of family based interventions, including preliminary data from MFT studies, we know very little regarding the process of change taking place in the families during the treatment course.

Furthermore, very little is known about what makes these interventions useful for this patient population group and their families. As discussed in chapter 2, although family interventions prove to be effective, the underlying assumption being that the family has had a role in the development of the disorder has not been empirically substantiated. Instead, families containing an anorexic offspring can be assumed to be rather similar to those

families with no index patient. With this respect the idea of family based interventions as a means to "correct" the family's dysfunction thought to be of a pathogenic nature is at least misleading for patients, families and clinicians alike.

Nevertheless, research exploring family factors and outcome in anorexia nervosa has revealed certain relevant associations which when viewed in light of the above, point to a rather different direction. That is, family factors may have a role to play in enhancing and/or inhibiting therapeutic effects. In other words, the way a family is organized around the illness and their anorexic relative may predispose certain families to respond better to family based interventions than others. Similarly, these interventions might have an effect on the patient's outcome by ameliorating the negative effects the illness has on the family. As to MFT, thoughts regarding its therapeutic potentials remain highly speculative and with very little specificity with respect to eating disorders patients.

Our lack of knowledge regarding the effective ingredients of these interventions could possibly be accounted for by the lack of process research in the area. Furthermore, even when process research is being conducted this is usually done from the clinicians'/ researchers' perspective while it is only rarely and mainly on an anecdotal basis that service users perspective on the treatments they receive is systematically addressed.

5.3) QUANTITATIVE AND QUALITATIVE APPROACHES IN THE PRESENT STUDY: Going full circle.

The present study has attempted to explore in detail and in a longitudinal nature the story of a number of adolescent anorexia nervosa patients and their families undergoing the newly developed Multiple Family Therapy (MFT) treatment.

Firstly the patients' and families' treatment experience will be thoroughly explored. Then, the patients' response to the treatment in terms of symptoms, psychological functioning and eating disorders psychopathology at 3 and 6 months follow-up will be examined.

The study will also look at the role of family factors in both predicting response to treatment as well as whether there is any change in family factors during the course of the treatment with a corresponding influence on outcome. In order thus to go "full circle" from symptomatic outcome through family factors to treatment experience both quantitative and qualitative methods have been employed in order to address the following hypotheses:

1) Explore the patients' and families' experience of treatment and draw comparisons between perceptions of patients and those of other family members
2) What is the patients' outcome, in terms of symptoms and psychological functioning at the three and six month's follow-up?
3) Do family factors change during treatment?
4) Are baseline family factors predictive of symptomatic outcome?
5) Does change in family factors have a corresponding influence on patients' symptomatic outcome?

The first issue referring to the patients' and families treatment experience will be thoroughly looked at by means of a qualitative analysis while the four later hypotheses will be examined by means of a quantitative methodology. The specific methods and procedures employed will be discussed in detail in the respective chapters of this thesis under the headings of ***Qualitative Methodology*** and ***Quantitative Methodology.***

5.4) THE CONTEXT OF THE STUDY: A brief description of the treatment

Multiple Family Therapy (MFT) for anorexia nervosa is a new treatment program that has been developed over the past three years at the Maudsley Hospital (Dare & Eisler, 2000) and at the Eating Disorder Service in Dresden (Scholz & Asen, 2001). The treatment provides a more intensive form of family intervention than the usual outpatient family therapy but is conceptually very similar. In common with the Maudsley Model (Dare & Eisler, 1995; Lock et al., 2001; 2002) of outpatient family therapy, MFT aims to help families rediscover their own resources by emphasising ways in which parents can take control of their child's re-feeding. At the same time the families are encouraged to use the group setting to explore how the eating disorder and the interactional patterns in the family have become entangled, making it difficult for the family to follow the normal developmental course of the family life-cycle. The sharing of experiences and the dynamics of the multiple family group is an important component of the treatment.

This treatment program combines elements of multi-family discussion groups that have been used successfully with a range of patient groups (McFarlane, 1991; Slagerman & Yager, 1989; Steinglass, 1998) and day treatment programs that that have been used with adult eating disorder patients (Kaplan & Spivak, 1996; Piran & Kaplan, 1990; Woodside et al., 1995).

The program starts with an intensive one week multiple family day program for up to 8 families who attend 9am-5pm. This is followed by a further 4-5 one day meetings at 4-8 week intervals. Individual family meetings are scheduled in the intervals between the group

meetings as needed with the overall length of treatment of each family being up to 9 months. A wide range of intervention techniques is used (including group and family therapy techniques, as well as psycho-educational and creative techniques) with multiple family, parent or adolescent groups as well as individual family meetings taking place (see Appendix I for example of an MFT day). There is also practical input around managing mealtimes and food (Dare & Eisler, 2000). Mealtimes are an integral part of the therapy providing the opportunity for directly addressing food related issues as well as unstructured, informal conversation between staff and families. The MFDT progresses in the three following treatment phases:

The first treatment phase is symptom oriented while much work is done to promote group cohesion as well as motivate the families. The major aim is that parents take full responsibility to manage the illness specific characteristics of their child. This is done by setting appropriate boundaries while not getting involved in continuous negotiations and re-negotiations about how much needs to be eaten within what time frame. Eating issues remain the focus of this stage, partly because this is where problems of family communication and interaction. Any other family or individual problems in the index patient or other family members are deliberately ignored during this phase. This appears to be a very difficult stage of the treatment and group cohesion is central in helping families endure these first difficulties. Support between parents from different families, especially during meal times, seems to be facilitating this process. The therapist at this point should try and support the parents in their efforts while avoiding to be drawn into role modelling or being in charge of the child's eating.

In the second phase the establishment of healthier eating patterns remains a central goal. However, the emphasis gradually shifts to also address relational issues in the family, such as family hierarchy, triangulation of the patient, communication disturbances, inappropriate emotional involvement, covert coalitions, secrets and other issues. In this phase the 'place' and 'role' of anorexia in the immediate and wider family context is explored and addressed. Available internal and external resources are identified and the family is encouraged to consider how to make good use of these. New specific goals are also identified. Long-term and trans-generational family patterns are examined and challenged.

The third phase is very much geared towards the future with this including relapse prevention as well as family issues and ways of coping that are not related with the eating disorder. During this phase there is a likelihood of autonomy and individuation issues to emerge both with respect to the eating disorder (e.g. is my body issue) and other areas of negotiations between the adolescent and the parents. The consequences of more independence are explored, both within individual and family contexts.

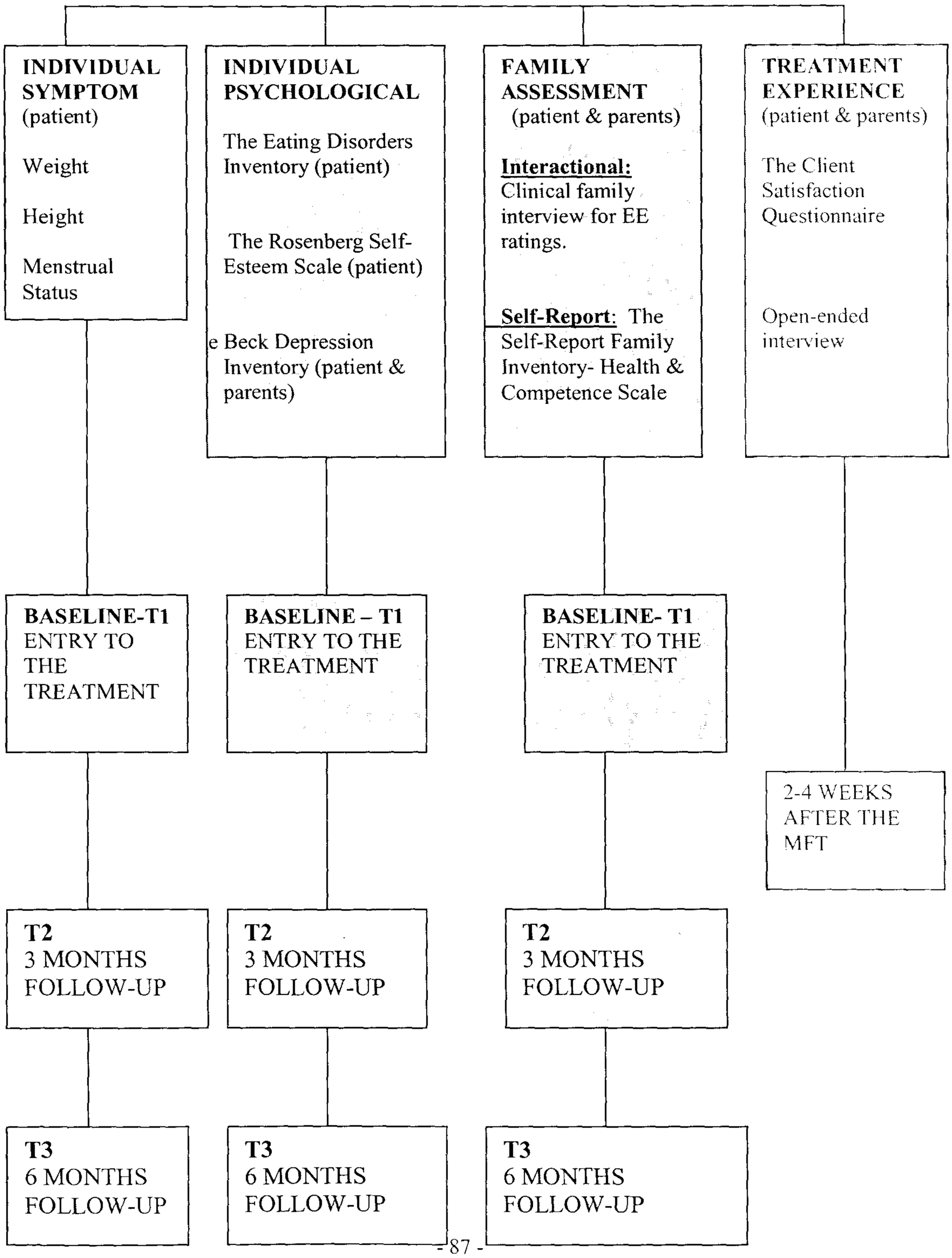
5.5) THE ASSESSMENT OF PATIENTS AND FAMILIES

For the assessment of the patients and their families a single cohort, repeated measures design was employed. Participants were evaluated at entry to the study being before the MFT (T1 baseline), and then at T2, which was three months into treatment, and T3 being six months into treatment. In those instances the patients' individual biological and psychological assessments were completed as well as the family interactional assessments. In between T1 and T2 assessments and after participants have attended the 4 day MFT program a further assessment was conducted regarding the patients' and families

experience of treatment (see Figure 1 below for a diagrammatic representation of the assessment procedure). Approval by the local research ethics committees of the Institute of Psychiatry and St. Georges Hospital, London has been granted for both the quantitative and qualitative components of the study. Written informed consent was obtained by both patients and parents once they agreed to take part in the study.

Figure 1

Quantitative & Qualitative Assessment Procedure



5.6) THE PATIENTS AND THEIR FAMILIES

The patients and their families recruited for the quantitative and/or qualitative components of the study were 30 consecutive referrals at the Maudsley and St. George's NHS Trusts Eating Disorders services. Inclusion/exclusion criteria for eligibility for either quantitative and/or quantitative components are described in detail in the respective sections of **qualitative** and **quantitative methodologies** of this thesis. However, table 4 below illustrates the main patient, family and illness/treatment related characteristics of the families.

Table 4. The patients and their families

Family Of	Patient Age	Birth Order	N of Siblings	Family Structure	Patient @ School	Parent(s) At work[1]/ Socio-economic status[2]	Length of Illness	N of previous admissions	Admitted during study follow-up	Aprox. N of FT[3] sessions Prior to MFT	Quanti. Assess-ment	Quali. Assess-ment	Drop-out (MFT/ study)
Angelika	15	1st	3	nuclear	FT	FT(both)/ I	6 mnth	0	no	5	yes	yes	no
Athena	11	1st	0	nuclear	FT	FT (fa) / I	4 mnth	0	no	5	yes	yes	no
Elena	15	1st	0	divorced	FT	FT (both)/ II	4 mnth	0	no	6	yes	yes	no
Nicholas	17	1st	0	nuclear	No	FT (fa) / IV PT (mo)	2 yrs	2	no	4	yes	yes	no
Joanna	14	1st	1	divorced	FT	FT(both) / IV	3 mnth	0	no	4	yes	yes	both
Katerina	16	1st	1	nuclear	FT	FT(both)/ III	5 mnth	0	no	3	yes	yes	no
Artemis	12	1st	0	nuclear	FT	FT(both)/ III	6 mnth	0	no	2	yes	yes	no
Judith	14	2nd	1	nuclear	No	FT(both)/ II	2 yrs	3	no	3	yes	no	no
Elizabeth	16	2nd	2	nuclear	No	FT(both)/ I	5 mnth	0	no	4	yes	no	no
Marilia	16	1st	2	nuclear	FT	FT (fa) / I	1 yr	0	no	2	yes	yes	both
Heidi	12	1st	1	nuclear	FT	FT (fa) / II PT (mo)	5 mnth	0	no	3	yes	yes	no
Lisa	16	3rd	2 (half siblings)	reconstituted	No	FT(both)/ II	16 mnth	2	no	2	yes	yes	no
Anne	18	2nd	1	nuclear	No	FT(both)/ III	3 yrs	2	no	4	yes	no	no
Carol	13	1st	1 half sibling & 1 step sibling	reconstituted	PT	FT (fa) / III	3 yrs	1	no	5	yes	no	no
Janet	18	2nd	1	nuclear	FT	Retired/ I	1 yr	0	no	6	yes	no	no

[1] Full Time job (FT)/Part Time job (PT)/ Father only (fa)/ Mother only (mo)
[2] Registrar's Classification of the family's socio-economic status based on the main breadwinner of the household
[3] Individual Family Therapy Sessions

Table 4. The patients and their families (continued)

Family Of	Patient Age	Birth Order	N of Siblings	Family Structure	Patient @ School	Parent(s) At work[4]/ Socio-economic status[5]	Length of Illness	N of previous admissions	Admitted during study follow-up	Aprox. N of FT[6] sessions Prior to MFT	Quanti. Assess-ment	Quali. Assess-ment	Drop-out (MFT/ study)
Christine	16	2nd	1	nuclear	No	FT(both)	6 mnth	0	no	3	yes	yes	no
Maria	16	1st	1	nuclear	FT	FT(both) /III	9 mnth	0	no	5	yes	no	no
Anthony	18	1st	0	reconstituted	No	FT(both)/ III	5 mnth	0	no	2	yes	no	both
Nicole	14	1st	1	adoptee	PT	FT(both)/ II	4 mnth	0	yes	4	yes	yes	no
Danae	15	3rd	2	nuclear	no	FT (fa) / I	1 yr	2	no	2	yes	yes	no
Karen	15	3rd	2	nuclear	FT	FT(both)/ II	2 yrs	0	no	4	yes	yes	no
Sandra	17	2nd	1	widowed (father deceased)	FT	FT(mo) / II	9 mnth	0	no	3	yes	no	no
Daphne	14	1st	0	divorced	FT	FT(mo)/ III	8 mnth	0	no	6	yes	yes	no
Lara	14	2nd	1	nuclear	FT	FT(fa) / III	6 mnth	0	no	5	yes	yes	no
Nadia	14	3rd	2	nuclear	No	FT(fa)/ II	7 mnth	1	yes	3	yes	no	both
Anabelle	16	1st	0	nuclear	PT	FT(fa)/ III	3 mnth	0	0	7	yes	yes	no
Pennie	18	1st	0	divorced	no	Unemployed/IV	3 yrs	0	0	5	yes	no	no
Susan	16	1st	1	nuclear	no	FT(both) /IV	3 mnth	0	0	3	yes	yes	no
John	15	3rd	2	nuclear	PT	FT(both) /II	14 mnth	1	0	7	yes	no	no
Julia	14	2nd	1	nuclear	no	FT (fa)/ IV	1 yr	0	0	4	yes	yes	no

[4] Full Time job (FT)/Part Time job (PT)/ Father only (fa)/ Mother only (mo)
[5] Registrar's Classification of the family's socio-economic status based on the main breadwinner of the household
[6] Individual Family Therapy Sessions

PART II

QUALITATIVE COMPONENT OF THE STUDY

CHAPTER 6

QUALITATIVE METHODOLOGY

In this section the qualitative methodology employed in the present study will be presented in detail. In line with the "evolving guidelines" for qualitative research (Elliot et al., 1999) transparency will be attempted with respect to the methods employed, their selection and relevance to the subject matter of investigation as well as the role of the researcher throughout the design, data gathering and analyses of the material. Also, relevant dilemmas regarding selection of methods and analytic procedures will be described to provide a clear account of the specific steps taken and the underlying reasons why.

6.1) THE PARTICIPANTS

A sub-sample (n=18 families) of the families who have participated in the quantitative component of this study (described more extensively in Chapter 9 on Quantitative Methodology) were approached for this qualitative enquiry on helpful and unhelpful aspects of the treatment process. Unlike quantitative data where sample size is determined by power calculations in qualitative research the process of data collection and analysis can run in parallel and data collection is due to finish once the material reaches maturity. That is when the same and/or similar themes start emerging (Silverman, 2001) and this was the approach adopted in the present study

Inclusion and exclusion criteria were the same with the ones described in the quantitative methodology only this time, patients and/or family members had to have attended, at least some of the MFT sessions, to be eligible. Out of the 18 patients approached, one declined and the interview recording of another patient was inaudible and thus hasn't been rated. As for the parents, all eighteen mothers took part, five fathers did not attend the MFT and thus

were not eligible for this part of the study, while in another three of the families fathers could not make themselves available for the procedure of this qualitative component. Therefore the interviews of eighteen mothers, ten fathers and sixteen patients (15 female; 1 male) constitute the material of this study. The participants in this study are not significantly different in terms of age, illness related characteristics, socio-economic status and EE levels from the larger sample used in the quantitative component.

6.2) THE RESEARCHER

A fundamental difference between qualitative and quantitative methodology is to be found in the role ascribed to the researcher with the former favouring independence and objectivity on behalf of the researcher and employing standardized instruments and procedures to ensure that this is maintained. In qualitative enquiry on the other hand, with the researcher playing a central role in creation of meaning and interpretation of material it is important to maintain a transparency as to his/her perspective(s) and values especially with respect to the subject matter under investigation. As Elliot and his colleagues (Elliot et al., 1999) put it *"this disclosure of values and assumptions helps readers to interpret the researchers' data and understanding of them, and to consider possible alternatives" (Elliot et al., 1999; p. 221).*

I have developed an interest in the treatment experience of families and patients undertaking the MFT treatment alongside the process of developing this thesis. At the initial stages of this process I have participated in a number of MFT groups conducted at the Child and Adolescent Department of the Maudsley hospital for young patients with Anorexia Nervosa and their families. Firstly I was interested in the changes that take place

within the patient and the family during treatment and their relevance to response to treatment which is part of the quantitative component of this study (discussed in an earlier chapter). Alongside this process and having been involved with the treatment team I became increasingly interested in the families own account and experience of the treatment process. This came about by observing the difficulties some of the families seemed to have with the intensity of the MFT treatment as well as the difficulties some of the team members experienced with some of the families during treatment. This was complemented by the fact that most of the families were reluctant to engage in a group treatment at the beginning; once there, they appeared to be overwhelmed by the intensity of the treatment. Indeed there have been considerable occasions where family members would have outbursts of tears, anger and the like during the MFT treatment; nevertheless, even the most "difficult" families would complete treatment with very few of them dropping-out. I therefore thought that despite its associated difficulty, this treatment should somehow have an element that "makes sense" to these families and have thus embarked on the journey of unravelling what it is.

Further to that and in designing the quantitative component of this study which involved extensive literature reviews in the area I have realized how much research is conducted from the researcher's and/or clinicians' perspective and how preciously little we know about the perspective of the receiving end.

My own involvement in the treatment process at the initial stages of this thesis has been very fruitful in terms of reflection and corresponding ideas and hypotheses about the usefulness of this treatment for those families of young anorexia nervosa sufferers. This has been quite useful in the process of relating and engaging with the participants when

conducting the interviews; in other words I myself have experienced and taken part in the exercises, interventions and conversations they were talking about. I was however aware of the possibility of my own involvement with the MFT treatment in distorting the participants' perspective. In other words I was cautious not to lose sight that it was their first hand experience I was interested in rather than using them as a way to voice out my own experience of this treatment. The possibility of this happening could take place both at the stage of interviewing the participants as well as during the analyses of the results.

As noted above one of the purposes of the study was to give participants a voice with respect to their treatment experience. Once embarked in that journey I have realized that this task appeared easier than it actually was, at least to my old, less experienced self. I had to face a multiplicity of dilemmas in both how to gather the information as well as in how to analyse it in a meaningful way and without compromising the richness of the material that the respondents have trusted upon me. In the next two sections I will describe the dilemmas faced and decisions taken with that respect

6.3: DEVELOPING AND CONDUCTING THE INTERVIEW

I have decided on an interview method guided by my belief that it was the only way to gain some sort of access to the richness and complexity of the respondents' experience of treatment. Also, taking into account the possibility of personal, sensitive and sometimes upsetting information that the participants could disclose I decided that face-to-face contact, as opposed to telephone interviews, would facilitate a certain amount of relating and would provide a better context, also on ethical grounds, for the interviews to be conducted. Some of the families I visited at home and some came to the Maudsley, it was up to them.

Another issue involved conducting the interviews with the entire family or with individual members. I thought that in that instance I was more interested in each individual's account of the treatment which could, in a joint interview, be overshadowed by other, perhaps more articulate family members' accounts. Similarly an individual interview would allow more space for opinions to be expressed especially if these were at odds with those of another family member and/or too sensitive and/or upsetting to be expressed in front of other family members.

These were just a few of the dilemmas and questions I had to face regarding the interview process with possibly the major task being deciding what the interview questions would enquire about. After all, my aim was to provide a context in which the participants' experiences would emerge rather than guide them according to my own pre-conceptions of what their experience would be like.

With this respect my initial inclination was to conduct completely unstructured open-ended interviews simply asking what the MFT treatment has been like for them. In closer consideration though I have taken into account the observation of the MFT being a very intense and overwhelming experience and with this respect such an unstructured open-ended interview might be equally overwhelming; in other words participants wouldn't know where to start from. So I needed to provide an interview context that would have a certain degree of structure mainly helping participants to organize their thoughts but at the same time would not impose my own ideas and preconceptions. Therefore, what seemed appropriate was a series of open ended yet focused questions.

I have thus borrowed aspects of the methodology that has been used previously in group therapy and family discussion groups (e.g. Lemmens et al., 2003a; 2003b) and adapted it to the needs of the present study. Lemmens and colleagues (2003a, 2003b) enquired their participants of family discussion groups in a psychiatric day clinic about helpful aspects of the treatment taking place at the individual patient, the family and the group level.

This line of exploration starts with two somewhat arbitrary assumptions: firstly that helpful aspects do take place and are perceived as such and secondly that they take place, as distinct entities, in the three above mentioned levels. In order to address this I have decided to enquire about both helpful and unhelpful aspects of the treatment; after all if I am to make this arbitrary assumption it has to be even-handed allowing for unhelpful aspects to be revealed as well. Furthermore and during the interview process I would acknowledge the possibility of lack of helpful and/or unhelpful aspects and events which was done mainly to make it more of an enquiry to be explored rather than request an answer to something that I wasn't sure it occurred in the first place.

As for the distinct levels of the individual patient, the family and the group their employment in their present study, contrary to the work of Lemmens and colleagues (2003a; 2003b), is not guided by the belief that these are the levels where therapeutic change necessarily takes place, this indeed is to be explored. They have rather been included to provide the respondents with a framework facilitating discourse and recall of their overall experience. In other words the interview was developed to work both as a stimulation generating relevant discourse and at the same time serving as a memory aid rather than to uncover concrete, specific experiences occurring at predefined levels.

The interview has also been complemented by a couple of generic questions asking about the participants general, overall impression of the MFT as well as about things they would have liked to have been different in the treatment (see Appendix II for open-ended interview questions).

The interviews were conducted between 2 and 4 weeks following the 4 day intensive block of the MFT. This was done in order for it not to be too soon following the first, 4 day block as families appear to be almost euphoric at the time but also not too far after, as their perspectives might be more determined by how the patient has actually done in terms of improvement rather than by what the treatment felt like.

In order to deal with the possibility of my own thoughts and ideas indirectly guiding participants during the interview I have tried to minimize any sort of probing on my behalf to instances where I would really be unclear about something the participants were expressing. After all, most participants were articulate about their perceptions of the treatment and would also go in quite a depth in their descriptions so indeed the further questioning and/or probing could bare the added disadvantage of irritating the respondents.

I think that conducting this interview has enriched my own perceptions not only with respect to the subject matter of the study but also regarding my changing role in the process of relating with those families. Up to that point my contact with families of anorexia nervosa patients has taken place from the side of the independent researcher and/or as a member of a clinical team. In that instance I was asking the families to share with me their experience of the treatment, what it felt like for them, in other words to include me in their

world rather than try to comply to the world often imposed by a strictly clinical and/or research setting.

I was also surprised by the willingness of the participants to share that huge load of personal experience with me as well as by their level of articulation of their experiences. Indeed each participant with their own styles of speech and communication was more than able to point to the aspects of the treatment that were salient for him/her and also to discuss in depth about what each of those felt like. Interestingly this process seemed to be taking place in parallel to the interview process, in other words their perceptions of experience were not static but seemed to evolve as the interview progressed.

6.4: SELECTING AN ANALYTIC METHOD

One of the most overwhelming dilemmas involved the selection of an analytic method that would address the issues of this study at the epistemological level while making sense with respect to the main clinical questions. As noted above my aim was to give participants a voice and through that process enrich clinical and theoretical insight as to how this treatment is perceived by the patients and their families.

At the epistemological level I was initially inclined to employ Grounded Theory (Strauss & Corbin, 1990) or Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003b). Grounded Theory which historically preceded IPA is founded in the philosophical tradition of symbolic interactionism (Stern et al., 1981) originally developed as a discovery-oriented approach. Data is the main focus of the method as theory is thought to emerge from data. With this respect the researcher's task is to give respondents a voice while

acknowledging the symbolic meaning of their words and discourse and through that and with systematic techniques eventually *"allow the theory to emerge from data"* (Strauss & Corbin, 1990, p.12).

IPA involves an inductive analytic process in which themes are systematically identified from the data; it is phenomenological in the sense that it aims to the exploration of personal, individual accounts of the experience. A core feature of the approach is the dynamic process assumed to take place between participant and researcher with the former contributing the data and the later employing his/her interpretative ability. What therefore emerges is a narrative which has been co-constructed by respondent and researcher. The procedures employed by the two approaches have been extensively described (Smith & Osborn, 2003a; Strauss et al., 1990; Strauss & Corbin, 1997).

It therefore emerges that both approaches fitted quite well at the epistemological level with my original aim being giving the respondents a voice. However, grounded theory is geared towards theory development and IPA towards the co-construction of personal narratives while they both rely on small sample sizes (usually 5-6 cases are more than enough) otherwise the analytic procedures are so overwhelming that they become futile.

I, on the other hand was interested in the exploration of salient treatment processes and/or themes identified by the group of respondents rather than the personal accounts of a couple of families. This is not because I consider these accounts less interesting; it is rather a sense of lack of that sort of insight that guided my decision to try and identify these themes as they emerge from my entire sample. Once we have some idea about that, we can then proceed in future projects to the exploration of specific experiences of a couple of specific

families leading to the formation of concrete specific narratives as they emerge from case studies.

I certainly felt that at this point a reduction of the data and sample would be counterproductive.

I have therefore concluded that the most meaningful thing to do would be to content analyse the interviews towards the exploration of themes and sub-themes reflecting the respondents treatment experience while at the same time acknowledging the feelings and perceptions attached to those experiences. Content analysis is an accepted and widely used method of textual exploration, interview transcripts included, with the eliciting and examination of themes and categories emerging from the data being the theme of investigation (Silverman, 2001; Strauss et al., 1990).

On the other hand and in contrast with IPA and Grounded Theory approaches, the epistemological as well as the specific procedural aspects of content analysis are not clearly defined; they are rather left upon the researcher to decide according to the study framework. What is of paramount importance in content analysis is the sufficient precision of the categories developed ensuring a certain degree of agreement between different coders of the same material. As to how these categories emerge there is no restriction imposed by the method; they can be predefined in the sense of identification of certain words and/or phrases within a passage that can also be quantified (i.e. number of times the particular word or phrase can be found in the given passage(s) or they can be themes emerging from the data; the important thing is that they are identifiable and understandable by people outside of the original developer and/or coded of the categories.

6.5) THE ANALYTIC PROCEDURE

For the purposes of analysis, the interviews were transcribed verbatim and transcripts were content analysed in order to explore themes reflecting the participants' treatment experience. Participants' names were changed into fictional ones to ensure anonymity and comply with ethical and Data Protection guidelines.

In this analytic procedure and given the fact that there were no predefined categories to be imposed upon the data I started by reading and re-reading a number of transcripts (about 8 parents and 5 patient) and making initial notes that reflected the respondents' experience identified in the specific extract.

For instance the following passage was initially noted as reflecting this mother's sense of reduction of feelings of isolation:

> *"seeing that other people had struggled for a year or so like we had was definitely helpful because you do feel quite isolated otherwise, when you're dealing on your own" (mother of Marilia)*

Similarly the 2 following passages were initially noted as these parents' feelings of reciprocity between the group members:

> *"the whole thing was helpful really; everybody was there wanting help and everybody was trying to make as much input as they could" (mother of Danae)*
>
> *"it is also quite good to share information with people, it's good to share knowledge with people because you feel as though you are giving to them, not just taking all the time. I thing that was good" (father of Athina)*

In turn and going through this process many times for each of the transcripts it appeared that many of the initial notes clustered around similar themes that could in turn be grouped into more inclusive main categories. For instance what the first extract on reduction of isolation with the two following examples of feelings of reciprocity share in common is that they all refer to a sense on behalf of the parents of the development of a support network. So in that instance the development of the themes (e.g. reducing isolation, feelings of reciprocity) would come first and it was if and when these themes clustered meaningfully that a main category (e.g. support network) would emerge. This process was exhaustively repeated to the first 13 transcripts (8 parents and 5 children) until a sensible coding system of themes clustering into main categories emerged. The rest of the transcripts were analysed according to this coding system and this analysis was facilitated by the NVivo software (QSR International Pty Ltd & Melbourne, 2002).

All the interview transcripts were also rated by a second rater who is quite experienced in adolescent anorexia nervosa yet has no first hand experience of MFT interventions in that or indeed any other patient population. The second rater was given the coding scheme and was asked to independently rate all the transcripts making notes of things she found unclear and adding and/or removing themes and categories as she thought was appropriate. In turn we compared our ratings of the transcripts for convergence and divergence in terms of whether the categories and themes were identifiable in the first place and also it terms of our ratings and coding of each respondents transcript. A high degree of agreement (approximately 85%) existed between the two of us with respect to the emergence of categories and themes and sub-themes as well as the rating of each individual transcript based on the developed rating scheme. In the few instances of divergence we would discuss

and modify the rating of the transcript until wereached an agreement. The final list of Main Categories and Themes and Sub-themes is presented in table 5 below.

Table 5. Categories, themes & sub-themes emerging from the analytic procedure		
MAIN CATEGORY	**MAIN THEME**	**SUB-THEME(S)**
TREATMENT EXPECTATIONS	Feelings when joining the MFG	• Worry of Picking-up new tricks • Nervousness & Apprehension • Came in Desperation • Novelty Factor/Lack of alternatives
MFG PROCESSES	A Support Network for Parents	• Being Understood • Reducing Guild & Isolation • Sense of Belonging • Feelings of Reciprocity
	A Support Network for Patients	• Reducing Isolation • Support/Rapport & Identification between the patient
	Specific Interventions	• Family Lunch • Role-Play & Family Sculpt • Family Tree & Time line • Psycho-education
	MFG Environment (practical & relational)	• Group members mixing well • Confidence on the clinical team • Time and Space • Comparing Notes
PERCEIVED CHANGES DURING/DUE TO THE MFG	Perceived Changes in the Patient	• Outcome of patient • Realization of AN
	Perceived Changes in the Parent(s)	• Gaining Insight into AN (reality/empathy) • Strengthening the Parent(s) o Hope/optimism/determination o Self-Efficacy o Parental Authority o Improved Relations/communication
FUTURE DIRECTIONS	Some Suggestions	• More variety • More parallel adult/adolescent groups

At a relatively early stage of this analytic process the issue of how each theme was perceived by the respondents emerged. In other words identifying the salient themes was half the purpose of the analysis with the other half being to explore how these themes, reflecting treatment processes, were perceived by the participants. With this respect a close observation of the data indicated that the helpful/unhelpful dichotomy adopted in the interview was quite oversimplified. The four following levels of experience with that respect emerged from the participants' responses. It is interesting to note the examples of different participants talking about their perception of the role-play and the family tree intervention(s) at the four different levels of experience identified in the study:

- **Positive Experiences:** In that instance the experience associated with the theme was a positive one and the process also perceived as therapeutically relevant and, usually without associated distress. Sometimes a sense of relief was apparent in that level of experience.

> *"I've found the role play ever so powerful[...] it makes you actually more determined because you understand how much a force is there so you're more determined to actually try and get rid of it" (mother of Nicholas)*

- **Negative Experiences:** Mainly involving events and/or aspects of the treatment perceived as distressing, stressful, painful, draining without any associated sense of short and/or long term benefit and/or therapeutic relevance. Overall, these experiences appear as if "not making sense" to the respondents.

> *"they made me do staff, strange staff, especially the role play. I didn't like standing up in front of everybody, didn't like talking in front of everybody, quite honestly I never want to do it again" (Elena-patient)*

- **Difficult yet helpful experiences:** These reflect a rather more complex process observed in the respondents. That is, it refers to experiences which despite the level of associated distress, anxiety and painful emotions are at the same time perceived as being of therapeutic helpfulness and relevance. In other words these processes seem to be stressful yet making sense for the participants within the context of the MFT treatment. These sorts of experience may sometimes involve the participants revising their opinion regarding processes initially perceived as unhelpful and/or difficult to due to the associated distress but which nevertheless seem to eventually make sense to the participant especially when considered alongside the treatment context.

> *"and there was one particular day that was really quite traumatic and everybody was in tears. We did like a role-play thing and it was so upsetting, it was really dramatic but I think that was a turning point for some of them. Like Julie and Artemis seemed to have a change of view. That was a good thing about it but it was upsetting; I felt sad because I realised that all those girls, those lovely girls go through so much"(mother of Heidi)*

- **Uncertain/Confusing Experiences:** This last level mainly refers to events and experiences which have been salient enough for the respondent to be discussed in the interview, yet the respondent is not sure about it's perceived function (i.e. positive, negative, revised); the participant in that instance rather appears unsure and confused his/her self as to those experiences. The main theme of that

experiential level is the respondent's uncertainty and confusion as to why the specific processes/ events took place.

> *"uhm, I don't really understand the family tree bit. I thought that I don't really understand what was all that about" (mother of Joanna)*

Interview transcripts were rated and coded in parallel for the identification of themes as well as with respect to the experiential level of each identified theme. As noted earlier, all transcripts were double rated and a high degree of agreement was established not only for the coding of themes, but also for the rating of the experiential levels described. Parents were also categorized as high or low EE (on the basis of making 2 or more CC of their relative) and patients as coming from a high or low EE family if, at least one, of their parents was categorized as high EE. This was done to explore whether different themes and/or associated perceptions would emerge depending between participants depending on their EE levels.

CHAPTER 7

QUALITATIVE DATA ANALYSES

Following the analytic procedure as described in Chapter 6 a range of themes emerged reflecting the participants differing and/or similar experiences with respect to the MFT[7] treatment. Overall, according to the analyses the subgroups of mothers' and fathers' experiences of the treatment were quite similar; that is they were not more different between the two subgroups than were the responses found within each one of the subgroups (mothers/ fathers). This will thus not be reported as constituting two distinct entities but will rather be presented as reflecting the views of "parents". Patients on the other hand appeared to overall be quite different in terms of what they made of the treatment. The similarities and differences between the parents' and patients' perceptions will be described in more detail at the closer examination of each one of the themes that emerged.

Overall participants talked quite extensively about their feelings when joining the MFG which could also be seen as a parallel to their expectations about treatment. The participants also talked about processes encountered in the treatment including support network, specific interventions as well as the practical and relational environment perceived to have developed within the treatment context. The participants also talked in terms of changes perceived to have occurred during and/or due to the treatment which mainly involved perceived changes in the parents and perceived changes in the patients. Last but not least patients and parents alike provided some suggestions about aspects of the treatment that they might have liked to be different.

[7] At various instances in this section MFT will also be referred to as Multi-Family Group (MFG) which is the term very often used by both families and professionals in our service.

As described in Chapter six, there are various different levels of experience reflecting differing perceived therapeutic functions which can be associated with each one of the themes. In the rest of this chapter each individual theme and sub-theme(s) will be explored also taking into account its perceived therapeutic function for parents and patients. A summary of the results is shown in Table 6 below.

A more detailed presentation of the themes and sub-themes that have emerged from the analytic procedure will follow. Results are illustrated under the specific categories developed.

Table 6. Summary of qualitative findings				
MAIN CATEGORY	**MAIN THEME**	**SUB-THEME(S)**	**RESPONDENT**	**FUNCTION**
1)TREATMENT EXPECTATIONS	**1.1. Feelings when joining the MFG**	1.1.1. Worry about "Picking-up new tricks"	¾ of parents	Themes refer to expectations and feelings prior to joining the group rather than aspects of the treatment. As such, they have not been rated for therapeutic function/experiential level
		1.1.2. Nervousness and Apprehension	¾ of parents	
		Feelings of Desperation/Lack of Alternatives	½ of parents	
2)MFG PROCECCES	**2.1. A Support Network for Parents**	2.1.1. Being Understood	> ¾ of parents	Positive/ Helpful
		2.1.2 Reducing Guilt & Isolation	> ¾ of parents ~ ¼ of patients	Positive/Helpful
		2.1.3 Sense of Belonging	> ½ of parents	Positive/ Helpful
		2.1.4 Feelings of Reciprocity	> ½ of parents	Positive/ Helpful

	2.2. A Support Network for Patients	2.2.1. Reducing Isolation	> ¾ of patients	Positive/ Helpful
		2.2.2. Support/Rapport & Identification between the patients	~ ¼ of parents	~ ¼ Positive/Helpful ~ ¼ Negative/ Unhelpful ~ ½ Unsure/confused
2) MFG PROCECCES	**2.3. Specific Interventions**	2.3.1. Family Lunch	~ ½ of parents	~ ½ Positive/Helpful ~ ¼ Difficult yet helpful ~ ¼ Unsure/confused & Negative/Unhelpful
			~ ½ of patients	~ 3/8 Positive/Helpful ~ 3/8 Difficult yet helpful ~ ¼ Negative/Unhelpful
		2.3.2. Role Play	> ½ of parents	> ½ Positive/Helpful ~ ¼ Unhelpful ~ ¼ Difficult yet helpful
			~ ½ of patients	~ ½ Positive/helpful ~ ¼ Unhelpful ~ ¼ Difficult yet helpful

		2.3.3. Family Sculpt	¼ of the parents	Positive/Helpful
			1/8 of patients	½ helpful ½ unhelpful
		2.3.4. Family Tree	> ½ of parents	~ ½ positive/helpful 1 parent negative/unhelpful
			~ ¼ of patients	Unsure/confused/not making sense
		2.3.5 Time Line	~ ½ of parents	Positive/Helpful
			~ ¼ of patients	Positive/Helpful
		2.3.6 Psycho-education	~ ¼ of parents	~ ½ Positive/Helpful ~ ½ Unsure/Confused
		2.3.6 Psycho-education	~ 1/8 of patients	Positive/Helpful
2)MFG **ENVIRONMENT** ***PROCESSES*** **relational)**	**2.4. MFG (practical &**	2.4.1. Group Members Mixing Well	~ ½ of Parents	Positive/Helpful
		2.4.2. Confidence on the clinical Team	~ ½ of Parents	4/5 Positive/Helpful 1/5 Negative/Unhelpful
		2.4.3. Time & Space	~ 1/3 of Parents	Positive/Helpful
		2.4.4. Comparing notes	~ 2/4 of Parents	Positive /helpful

3) PERCEIVED CHANGES DURING/DUE TO THE MFG	**3.1. Perceived Changes in the Patient**	3.1.1. Outcome of patient	~ 1/3 of Parents	Positive/Helpful
		3.1.2. Realization of A.N	~1/5 of Parents	Positive/Helpful
	3.2. Perceived Changes in the Parents	3.2.1Gaining Insight into the Illness (reality/empathy)	~ ¾ of Parents	~3/4 Positive/Helpful ~1/4 Difficult yet helpful 1 parent negative/unhelpful
			~ 1/5 of Patients	Positive/Helpful
		3.2.2. Strengthening the parents a) Hope/optimism & determination	>3/4 of parents	Positive/Helpful
			~1/4 of Patients	Positive/Helpful
		b) Self-Efficacy	½ of Parents	Positive/Helpful
		c) Parental Authority	¼ of Parents	Positive/Helpful
			1/5 of Patients	2/3 Positive/Helpful 1/3 Negative/Unhelpful

		d) Improved relations/communication	2/4 of parents	>2/3 Positive/Helpful <1/3 Negative/Unhelpful
			1/8 of patients	Positive/Helpful
4) FUTURE DIRECTIONS	**4.1. Some Suggestions**	4.1.1. More parallel adult/adolescent groups	½ of patients ¾ of parents	These themes reflect participants' wishes and suggestions rather than aspects of the treatment. As such, they have not been rated at their experiential level.
		4.1.2. More variety	¾ of patients	

7.1: INITIAL EXPECTATIONS

a) Feelings before/when joining the group

Some of the parents and a few of the young people talked about their feelings when they were initially offered the treatment option of the MFT group. They talked about their expectations, or indeed lack of specific expectations when first joining the MFG as well as about their worries, uncertainties and anxieties at the initial stages, when they were still trying to make up their minds as to whether they were going to take up the MFT Group treatment option or not.

Worry of picking-up new tricks

Many parents endorsed the notion of worry that their daughter/son may learn new anorexic behaviours and/or tricks from the other young people attending the group.

> *"... that was the thing I was worried about in the MFT; that she'd meet other people and you learn all these other tricks and that was one of my fears." (mother of Katerina)*

Nevertheless, most parents acknowledge that although this was one of their main worries, when thinking about it in retrospect, they tend not to perceive this negative effect to have taken place.

> *"The only thing we were concerned about when we came into it were that she would perhaps learn about other things she could do to loose weight that she hasn't perhaps tried, but I don't think that she's taken on board any of that stuff."(mother of Julia)*

Desperation/Lack of Alternatives

Some of the parents described being in absolute despair when coming to the MFT Group which was viewed at the time as a last resort really while for some of those parents the initial sense of despair was dispersed by attending the group.

> *"Three words: it was brilliant. It really was. Before I went I couldn't see the light at the end of the tunnel. I suppose I was slightly in despair before I went and on the second day it was like a cloud going up. I had this cloud and it lifted and I felt it was really helpful. Yeah, that's how I felt. I just felt it was so good an so helpful" (Mother of Danae)*

A couple of the parents also talked about their sense of lack of appropriate treatment and/or response by the services which in turn lead them to approach alternative treatment centres/clinics. In the first example this was done in the midst of the mothers' desperation at not getting any help while in the second instance it reflects another mother's belief that the psychological side of her daughter's illness was being overlooked by professionals. Both examples though highlight these parents feeling that their child is in eminent danger while this is not being appropriately addressed.

> *" I tried, I tried so hard I could see what was happening and I tried so hard to get the help and I couldn't get it; all I was told was that she needed to eat and I tried so hard I went to the GP, all in one day, I phoned up the local team and I went to the GP and in the end, and I spoke to, and in desperation I went to an alternative clinic, ahh, and there was a psychotherapist there and I made an appointment. I was so desperate because of what she was saying I made an appointment with his, I didn't know who he was, I made an appointment, I was so desperate" (mother of Danae)*

> *"Before I went I was chatting with a lot of people who were into alternative medicine, I was beginning to go down that road; hypnotherapy, hypnosis, acupuncture, if that would work (small laugh) Uhm, you know, I was thinking about going down that angle because I kept thinking that all the doctors were concerned with the physical side, what she*

weighed and what she ate which is a valid point but so much I was worried, I still am, about what is going on in her head so I was sort of going down the psychological side and then when we went to the group I sort of realised that you have to sort their physical side out first" (mother of Julia)

Nervousness or Apprehension.

Parents also described feeling nervous or apprehensive before attending the group for the first time, but found it a positive experience when they had attended.

I'm glad we did it really, definitely, because at one point we thought we wouldn't come I do feel it's helped [...]I was sort of dubious about coming, uhm, I found it to be a really positive, overall [...] you know, we really appreciated being involved although we were kind of nervous and not quite sure what to expect when we first came along ..."(father of Katerina)

A number of different factors were reported to produce these feelings of nervousness and apprehension. These factors ranged from worry about the time commitments and missing work to meeting with other families and participating in group work. Nevertheless most parents seemed to believe that the benefits of the MFG outweighed the difficulties of managing to commit to the 4-day structure of the treatment.

"I think it was useful really. At the time I wasn't sure if I was going to go but I'm glad that we did really [...] I wasn't sure if it was the right thing at the time and also taking time off as we had a big job that week but they've sorted that out for me. But I'm glad that we did do it. It's hard work and was in a bad mood, it's very tiring and very draining. I wouldn't want to have missed out on the experience. I think I've learnt a lot about anorexia in that week." (mother of Heidi)

For some parents this sense of nervousness and apprehension seemed to be stemming from their skepticism regarding the processes involved in the MFG as well as the possibility of doing more harm than good to any already achieved progress.

> *"I was skeptical because I suppose we are very new to the process. We haven't been coming for long and I was skeptical in the fact that how could anyone else understand what it is like" (mother of Katerina)*
>
> *"It was excellent. I didn't want, I was very unsure about coming, I did say that to [CONSULTANT'S NAME], because I felt we were getting along and didn't want anything to rock the boat. So I was nervous about coming and apprehensive about coming, but in fact I'm please I did. It was enormously helpful[...] I'm very positive about the whole thing having started off being very skeptical about it. Anybody else who'd have doubts about it I would say 'You should definitely go and just give it a go" (mother of Artemis)*

7.2: MFT PROCESSES

a) A support network for parents

The support developing between the parents seemed to be a very salient theme making a significant impact upon the parents themselves as most of them referred to the support network at one or various instances during their interviews while some of the patients also seemed to acknowledge the impact of support upon their parents. It is also interesting that both parents and patients only referred to the support network as having had a positive/helpful function in the treatment. Participants talked about their sense of a support network in terms of a number of inter-related, yet distinct sets of processes which involved: *being understood, reducing guilt and isolation, sense of belonging and feelings of reciprocity.*

Being understood

The sense of being understood seemed to have played a pivotal role in the parents' sense of a support network developing within the group. A key aspect however was the sense of being understood by people who were in the same boat; that is by fellow-parents of anorexic patients.

> *"I think just the fact that we could all talk about various different things that had happened to us individually and other people knew what we were talking about" (father of Athena)*
>
> *"and it was good to know there's someone who understands exactly" (mother of Lisa)*
>
> *"I've found it (MFG) really positive and the reason I think I found it really positive is that I met with a group of people who did understand what it was like living with Anorexia [...] I've not met with a group of people outside the Maudsey that actually had an understanding of what's going on" (mother of Katerina)*

For some of the parents the feeling of being understood also involved the illness related behaviour of their children that was not always perceivable by outside observers and/or the related challenging behaviour and associated difficulties that some of the parents were experiencing.

> *"Because they know that their child could be looking fairly healthy but they know that if they say: "go and have a cheese sandwich" it's actually hard to explain to people" (mother of Athena)*

It is interesting also to note how strong the feeling is for some of the parents that indeed unless someone is in the same boat as them they can't really relate and understand what they and their children are going through and this is irrespective of any sort of good

intentions. In other words it seems that for some of the parents no one who's not experienced what it's like living with and caring for an anorexic patient is good enough or as good as these fellow-parents with respect to sharing and supporting each other.

"I talk to everybody about it, I mean all friends, family, colleagues. Everybody who asks me about how Helen is gets the whole thing about Anorexia and they're very sympathetic and very very worried and all of these things but they don't really know, they don't really know , they're probably thinking: thank god it's not my child. So I think the reason it's so important is that you know that these people understand first hand how intolerable that level of anxiety is over a prolonged period"
(mother of Elena)

" I think it's just the comfort thing, I think it's comfort as much as anything else because people, if they're not actually dealing with an anorexic child they haven't got a clue. I don't care who they are, I don't care how many books they've read, I don't care how much research they do; unless you've been handling it for a year like we have and other parents and the day to day caring then I'm sorry, you know, outside people say this, that and the other, they haven't got a clue, they haven't got a clue. But these people have, and they are going through hell as well" (mother of Christine)

Reducing guilt and isolation

The parents in this study seem to have struggled with their sense of isolation while the realisation during the MFG that it happens to other peoples' lives and hence they're not the only ones struggling with an anorexic child seemed to have come as a relief in terms of reducing their perceived isolation and related feelings of loneliness.

"It (MFT group) was good, in the fact that, you know, you aren't alone" (mother of Julia)

"and it has certainly been helpful to know that this is going on in other people's lives as well" (mother of Elena)

"Also, ultimately you're not the only person who's kid has a problem" (father of Athena)

" Seeing that other people had struggled for a year or so like we had was definitely helpful to me, uhm, because you do feel quite isolated otherwise, when you're dealing on your own" (mother of Marilia)

For some of the parents who knew and/or could imagine that other families were in a similar position being brought in contact with those families was very important.

"Sometimes it's not so much that you feel on your own, you know there are other families that cope with it but you don't necessarily have access to them and how they feel [...] I knew there were other people who suffered from the same thing but never actually spoken to anyone who's had it or any families who were going through the same thing" (mother of Lisa)

All the parents who talked about reduction of feelings of isolation as a therapeutic process of the MFG perceived it as having a positive function. To that however there was one exception with one of the mothers talking about her persistent feelings of being on her own and lack of support despite the MFG

"Uhm, I think that even though I'm coming here and the group and everything I still feel as if I'm own my own. I feel that I come here and the group and Dr. [therapist] and [therapist] are suggesting things I still feel I'm on my own. I still feel that I'm fighting this thing on my own." (mother of Joanna)

Further to the feelings of isolation the parents in this study seem to also have struggled with feelings of guilt. These feelings of guilt and blame often go hand in hand with the sense of

isolation, or in other words the family's perception that they are one of the rare, dysfunctional families having an A.N sufferer. The idea of isolation as a factor maintaining feelings of guilt and blame is illustrated by the results below whereas by being in a group of other families seemed to have reduced these feelings of guilt through normalising their family.

> *"I think it was nice to, because after all, you know, if you're a family with a sufferer with this condition, it's instantly the feeling that somewhere you've failed, you know, you're below, you're not good enough, you've done bad. But then by meeting the other families and by the children expressing very positive views of their family, that made me feel good and made me feel: yeah, let's see this in a different way. You know, it's not very healthy to see this in this failure kind of way." (mother of Angelika)*

As illustrated in previously (table 25) about a quarter of the patients' sample talked about the beneficial aspects of the MFG support group for their parents. It is interesting that these responses when coming from the young people were focused, more than anything else, around the usefulness of the group in reducing their parents' isolation. At the same time some of those patients acknowledged the associated function of reducing feelings of guilt.

> *"I think seeing the other families in the same position helped them realise that it happens to lots of people and so it's nothing to do with them, that they've done something and also to talk to them about their experiences, to be able to understand how they feel and to feel like someone else is going through the same thing and that they can understand" (Danae-patient)*
>
> *"just seeing the other girls that she knows that there are other parents out there going through the same thing" (Julia-patient)*

Sense of belonging

An extension of the reducing isolation theme described above and possibly a result of this process is the parents' sense of belonging. In other words, it appears that during the MFG the parents move from a position where they feel they are on their own, the only ones with an anorexic child trapped in a lonely struggle through to the realisation that in fact there are other, indeed 'normal' families in the same position leading to a feeling that they belong to a closely linked support network that they can use and turn to during their times of need. More or less like a safety net that they may make use of and irrespective of whether they do or not it seems that just the thought of it is reassuring

" I often think about the other girls and wonder how they're doing and I'm sure they're thinking about Helen and wondering how she's doing so there is a sort of a shared bond thing which is quite nice" (mother of Elena)

" it's like, well what's the word? It's like an empathy between us all but it's almost like a little group of friends now, if you know what I mean" (mother of Artemis)

" we just felt we belonged together and we were all brought together by our children" (mother of Lara)

Central to the sense of belonging was described to be the feeling that group membership and associated support was something persistent over space and time rather than confined to the designated days and times of group meetings and this involved both the other parents as well as the availability of the professionals involved.

"caring and sharing and the think we can ring up and speak with the Maudsley, we have everybody's (other parents) phone numbers, we can ring up and say help, you know" (father of Lisa)

"well before it was, like where's your backing? I know you haven't got any backing now

so to speak but I have in a sense because I've got you here" (mother of Daphne)

Some of the parents also stressed the importance of having the follow-up days in their sense of belonging to a support network also linked with a smooth continuation of the MFG's therapeutic processes.

"This knowing that we're going back in a fortnight it was brilliant because it means that you're going to try and do things in that fortnight and then you're going to go back and get another spur and you get more help" (mother of Danae)

"also we took phone numbers at the end and e-mail addresses so that we could keep in contact, if we wanted to, during the time that we were not going to see each other and I think it's definitely a bonus that we're actually going to see them once a month, I think this is a very good thing" (mother of Lisa)

"I think we're quite looking forward on seeing how everyone has got on on Friday when we meet again" (mother of Marilia)

Feelings of Reciprocity

The parents' responses regarding their feelings of reciprocity towards other group members as being an integral part of the ongoing support process was striking. Indeed parents appeared to perceive the presence of the other families as something helpful to them, as also illustrated in the sections above, and in turn their willingness to reciprocate that and give something back to the group. Also the feeling of being helpful to the other group members seem to be somehow helpful in its own right.

"but it's also quite good to share information with people, it's good to share knowledge with people because you feel as though you are giving to them not just taking all the time. I think that was quite good" (father of Athena)

"it did develop in the group, I think, a sense of wanting to help one another" (mother of Marilia)

It was also interesting how one mother and one father talked about their feelings of reciprocity while at the same time acknowledging the difficulties encountered.

"the whole thing was helpful really. Everybody was there wanting help and everybody was trying to make as much input as they could although sometimes it was obviously very difficult" (mother of Danae)

"and also to offer support not just get support from other people but also to be able to offer it to others although we weren't really in a position to do that but some of the things some of the other families have said. Ellie's parents for example probably would have said they were glad to be able to offer some advice" (father of Elena)

An other way the parents' desire to reciprocate to the other group members is shown in the following extract of one of the mother's description of the very negative and also dangerous experience her daughter had while she was an inpatient and bullied by a fellow-patient who eventually attempted to strangle her. In that instance the mother is very concerned about the possibility of a negative effect of their story upon the other group members while it is as if her own pain of recalling this experience becomes milder by the possibility that other families may draw something positive out of it. In other words it is as if their own misfortune acquires a different meaning by the possibility of it being helpful for the other families.

"I hope I have been able to say some things that would help other families. But I hope what had happened to us won't make them feel more down [...] it wasn't very happy but they (hospital ward) did deal with it but I did say that to the others (group) and I hope it didn't make them feel more down. On the other hand perhaps what we've been through

might have helped the others. They might have drawn on the positive side" (mother of Danae)

b) A Support Network for the patients.

Most of the patients and the parents alike talked extensively about the supportive effect created by being in contact with fellow-patients. Like the parents in the previous section, the patients talked quite extensively about the positive feeling associated with the reduction of isolation brought about by meeting with other fellow-patients. The parents' views on the support network for their children were expressed in terms of support/rapport developing between the patients as well as their sense of a process of identification between the patients taking place during the MFG.

Reducing isolation

Most of the patients were very positive and quite articulate as to their initial feelings of being the only ones suffering from this illness and their sense of a lonely struggle and how this had been reversed in a way be meeting and being in contact with other sufferers of the condition.

"it was interesting to meet like the other girls and the other young people to be able to relate to" (Anabellel-patient)

"I thought it was very good, yeah, found it very good in that it was comforting meeting with the other people and realizing that I'm not alone and the only one with this illness. It was very good getting in touch with the other girls" (Christine-patient)

"I think it was really good that it gave me the feeling that it wasn't just me struggling against anorexia. It was like a lot of people, a lot of families, lot of therapists [...] it's more like I'm also part of a club where we all deal together with another problem and it's not just such a personal, lonely struggle (Angelica-patient)

Identification with fellow-patients

Some parents also commented on the effects of identifying with other patients in the group had upon their ill children. With this respect whether this was perceived by the parents as a helpful process or not varied depending largely on the perceived outcome and/or consequence(s) for the patient deriving by this identification.

For instance one mother perceived that as a way for her daughter to feel less isolated and also by observing the positive characteristics of the other patients infer them for her self as well, possibly thus linking it to increasing her self esteem.

> *"it has given her better understanding of anorexia as well. That it's not just her, it happens to these people who are all intelligent, the stigma attached is not so bad, they are all nice girls, nice families, you know, they weren't obese before getting in this condition and it's all that isn't it?" (mother of Christine)*

For another mother one important thing was that by seeing the progress in the other patients her daughter could gain some hope regarding her recovery especially at a time where she appeared to be so ill that it was difficult to imagine she could ever get better.

> *"I think, just going quickly back to Artemis, doesn't it make you feel that seeing the other girls, seeing a difference in the other girls getting better doesn't it make you feel that, you know, you will get better, just take some time because if they can get better; I think that was good for Michelle because I think she probably feels at the moment that it's too difficult" (mother of Artemis)*

A couple of the parents however talked negatively about the effects of this identification process upon their children especially when they perceived that their child was identifying with less desired behaviours as well as a worst course and outcome of the illness.

"Sadly Elena didn't identify very much with her (a patient getting better) and identified with Danielle who was an in-patient still and is clearly very sick. And it's her that Helen engaged with and is closer in age too and felt more affinity with which I found worrying because it was obviously that the place were she wanted to be and not the getting better and being able to eat bananas. It was helpful for me to see that children got better but it was worrying to see that Helen didn't identify herself with that at the time" (mother of Elena)

"I suppose what was slightly unhelpful was seeing some of the other girls, you know, in a bad state; I just worry she will pick up something, she might think that, uhm, that she gets assurance by the fact that other girls are in the same position and so therefore she's not the only one and to a certain extend that might hold her back a bit" (father of Christine)

A few of the parents seemed quite puzzled as to whether the identification of their children with the other patients had been helpful or not.

"there was a couple of the girls there that have been ill about a year but came to the conclusion that they don't argue, they have to eat to get better, they know they've got anorexia whereas a couple of the girls can't even say the word because they don't think it applies to them; so I'm sort of hoping that she would have accepted that without doing all this comparison but I think, I don't know really" (mother of Julia)

"I think she was surprised at how differently she felt from the other girls. When they went off on their own groups she was surprised, how, why felt they were not able to eat properly and the reasons were quite different, she felt, to her own reasons. Uhm, and that had surprised her, I think, she hadn't really thought about the reasons so that was surprising; maybe that was helpful, I don't know(mother of Marilia)

Rapport/ Support between the patients

Some of the parents commented on the above issue and whether it has developed in the first place. According to the results most parents commented on the development of a mutual support and rapport between the patients positively.

> *"**E.S:** Can you think of any aspects of the MFG that have been helpful to Nicholas?*
> ***Mum:** I thought he related well to Angelika (fellow-patient) talking and supporting each other, so yeah" (mother of Nicholas)*
>
> *"they've bonded really really well the girls and Christina and Jessica have gone on really really well even though Christina is quite older it was like a support for each other" (mother of Chrisitne)*

Most of the parents however, who commented upon the theme of support and/or rapport developing between the patients seemed able to acknowledge the positive potential of such an interaction while at the same time they didn't seem to think it has developed in the first place. For some of the parents this was attributed to the experienced difficulty on behalf of the patients when undergoing the treatment and the effect this has had upon the mutual interaction between the patients.

> *"I don't think, the girls didn't really mix, they didn't spoke to each other willingly, it was all sort of as a group but it seemed the quite liked to do the activities" (mother of Julia)*
>
> *"I don't think there has been a lot of interaction between the others helping each other" (father of Athena)*
>
> *"I would like, if the girls could gel a bit more; they didn't seem, they did their sessions, Mima took them separately, I know they are very uncomfortable and don't like talking but there didn't seem to be anything to get them relaxed in each others company" (mother of Nicole)*

Differing beliefs and perceptions between parents and patients.

Overall there seemed to be an agreement between parents and patients regarding the helpful aspects of a support network for the parents with the only difference being the higher degree of articulation on behalf of the parents as to how they have benefited from the various aspects of support. The patients tended to perceive support in a more one-dimensional way primarily impacting on their parents' sense of isolation.

The results were somehow more complex regarding the effects of a support network upon the patients themselves. Although the patients reported gaining some benefit from the interaction with fellow-patients, the parents generally seemed to not have perceived this interaction taking place in the first place as illustrated by the majority of the parents wishing for more support and rapport to have occurred between patients. The majority of the parents also worried that the identification between patients could also have negative effects upon their child's recovery.

c) Specific Interventions.

Overall the majority of parents and patients alike talked at some point during the interview about their experiences of the specific interventions employed in the MFT group.

An interesting observation was the lack of uniformity between parents and patients in how specific interventions were perceived in terms of therapeutic function. Some parents perceived some interventions as helpful and others as unhelpful, difficult yet helpful and confusing and the same was the case for the patients. These will be considered in more detail below as they relate to each specific intervention.

Family Lunch

More than half of the parent and patient sample commented on the family lunch with approximately equal numbers perceiving at helpful or unhelpful. Some parents viewed the family lunch as helpful either for them or for their children or indeed in strengthening the support and the mutual understanding within the group

"when we were eating together I thought it was a very unifying experience because it did make us aware of the problems that the other families were having were very similar[...] I think eating together was very good because it actually was very supportive, sort of a supportive environment and that was good" (mother of Katerina)

"I think probably the most helpful thing for her was actually eating together, particularly the lunch times because the staff were able to challenge her about what she eats and the sort of food she doesn't eat and hasn't been eating for a long time whereas she's not ready yet, she's not really wanting to get better they did actually get her to think about, you know, what she was eating and in the evening she said to me: 'are you going to make me do this tomorrow' you know, she was actually thinking about changing her eating patterns so it did sort of change her mind set that she was in" (mother of Julia)

Interestingly enough none of the patients who perceived the family lunch as helpful described it as such for him/her self as a patient, with most of them commenting on its helpfulness for other patients and/or for their parents

"we had to eat lunch all together in one dining room and my parents tried to push me eat with the other people and I think they found it helpful, other people being there and talking to the other parents and the support" (Lara-patient)

"lunchtime was good, it wasn't so funny but seeing the other girls eating; it didn't work for me but might have worked for some of the other girls" (Artemis-patient)

About a quarter of the parents and the patients respectively perceived the joined family lunch as a difficult yet helpful experience, with some of the parents describing the difficulties encountered in the first couple of days and how these mellowed in the following days making thus the lunchtime a beneficial event.

"in the beginning I though the lunch-time was unhelpful, but that was obviously part of it as well, the eating together. The first Monday lunch-time, that was very very strained, two days later it was a bit more laid back, it got us thinking that having lunch is a social thing[...] I just think you have to, there's no point doing the morning and then disappearing for an hour and then coming back, it felt like a big team effort"
(mother of Julia)

"initially, when it was first suggested I was: 'oh my god no way' but then after a few days we all automatically go into the room and everybody has their lunch" (mother of Christine)

The patients whose negative perception of the lunch time changed in retrospect acknowledge the eventual associated benefits for themselves and it is worth contrasting this with the responses of those patients who perceived lunchtime as a helpful event but as described above, did not associate it with any personal gains.

"although it didn't seem as helpful in the beginning the time when we all went and had lunch together, it was scary at first but then I think it did help quite a few of us because I think you have to be put in situations where it pushes you that little bit further and I think that was one; I think it helped all of us rather than going into separate rooms"
(Christine-patient)

"in the meals at lunch, I felt really really really, all 5 of us really didn't like it because I felt under so much pressure, you know, eating sandwiches and butter and stuff which is something I really hated. That might sound a bit weird, even though I've been eating more and more slowly I've always been very very controlled and I felt like someone else

was imposing on me. And that was good because I had to go through that, you know, someone actually forcing me, making me do it in a more uncontrolled way because I've realised that I won't always be able to control it and at some point I'm going to have to just loose this fanatic control. (Angelika-patient)

A small number of the parents and children found the joint family lunch to be an unhelpful experience. These parents seemed to have perceived the lunch-time as a situation that got out of hand and could not be contained by them as parents and in some ways by the clinical team either.

"at lunch-time we all had to try and sit and eat together and it was a disaster and I think it was a real shame that that couldn't be managed but it couldn't so that wasn't good" (mother of Karen)

"like, Joanna wouldn't eat, I don't know what they could have done but I do think more. Someone could have took Joanna aside and spoke to her. I don't know if that's the right thing to do, it might be the wrong thing to do but I was left to try and struggle when I know that at the end of the day I'm at home with her everyday and you guys aren't. But even here with you all around me I still felt I was on my own, she wouldn't eat and as much as nobody sort of looked at me and thought: 'oh, she's failing' but I thought that no one helped me either" (mother of Joanna)

As for the patients, the unhelpfulness of the lunch-time seemed to have been closely linked with the behaviour of the adults, parents and professionals, challenging the patients' eating which in that instance was perceived as showing lack of support and understanding regarding how difficult a task the lunchtime was for those sufferers of anorexia.

*" **E.S:** How about unhelpful events taking place? Did specific things happen during the MFG that you thought were unhelpful for you?*
***Julia:** Uhm, when we had to eat lunch together, some days the adults compare what we were eating and staff and I don't think they understood that we were finding it hard*

enough already[...] everybody had to eat their lunch and we were finding it hard enough already and you just wanted to forget about it and you know, you don't want to eat it all and the adults made it harder" (Julia-patient)

"I thought the lunch-time was stupid[...] putting us all together and obviously no one's wanting to start and no one is going to start. It was just annoying having all that adults together because you could hear them all like having a tape playing and I'm not going to listen to any of it because you could hear them all saying the same sort of things. Maybe when you're on your own it feels like they mean it more but they were saying the same things to everyone, it didn't really help at all" (Karen-patient)

Role Play & Family Sculpt

Overall the role play exercise seemed to have impacted upon the participants with more parents than children commenting upon it. Of those who commented, about half the parents and patients found the exercise helpful in terms of increasing parents' understanding of how strong a power anorexia has upon their child. Perhaps the one thing that stands out across the board regarding the experience of the role play and irrespective of whether it was perceived as a positive, negative, difficult yet helpful or confusing was how powerful and experience it had been for parents and patients alike.

"and also the role play with the food, with anorexia on my shoulder. That was for me also very powerful in trying to understand what is going on when the food is in front because you have no understanding of what's going on in their head, or why they can't eat, or why they become so anxious and violent" (mother of Katerina)

"with the role-play I think mum and dad understood what it sounds like in my head" (Nicole-patient)

Other parents felt that by this increased understanding they became stronger and more determined to fight and get rid of the illness

> *"I've found the role play ever so powerful[...] it makes you actually more determined because you understand how much a force is there so you're more determined to actually try and get rid of it" (mother of Nicholas)*

Also, both parents and patients commented on how the role play was mirroring the children's behaviour and thus making them understand what it felt like for their parents.

> *"when we did the role play, when we had to pretend to be our parents, that was quite interesting to try and put ourselves in their place (Anabelle-patient)*
>
> *"I think the role play was very powerful, I can see why you left it to the last day, it could have exploded but I think it was very powerful. It was helpful for the children to see the mirror of what their behaviour is like, to see what their parents are struggling with and at the same times the parents experiencing what it's like to have this thing" (mother of Angelika)*

Nevertheless, about a quarter of the parents and patients who talked about the role play perceived it as a negative event partly due to its intensity and the fact hat it was putting a lot of strain and pressure on people without actually making any sense and/or doing anyone any good.

> *"there was a point where we had to do enacting and I became sort of negotiator and I found that very very upsetting[...]I wouldn't do it again, I would just take the 5th amendment, I did it because I wanted to try and be of help but it was very difficult. I think that's possibly the worst bit of the whole 4 days[...] I don't think there was any benefit in it. I just think it was a pressure unnecessary for me and for Hank; I think it must have been very painful to watch and I think it got to appoint where we got so involved that I think we forgot who we were" (stepfather of Lisa)*

"they made me do stuff, strange stuff, especially the role play. I didn't like standing up in front of everybody, didn't like talking in front of everybody, quite honestly I never want to do it again" (Elena-patient)

It is also interesting to note the responses of those participants who talked about the role-play exercise in a revised way perceiving it as a difficult yet helpful intervention (4 parents and 2 children). They acknowledge the emotional difficulty associated with the role-play as well as the feelings of upset and distress experienced at the time yet a possible helpful and/or meaningful dimension is also attributed to the exercise.

"and there was one particular day that was really quite traumatic and everybody was in tears. We did like a role-play thing and it was so upsetting, it was really dramatic but I think that was a turning point for some of them. Like Alice and Sam seemed to have a change of view. That was a good thing about it but it was upsetting; I felt sad because I realised that all those girls, those lovely girls go through so much"(mother of Heidi)

"the role play was helpful because I had the chance to analyse the situation and it brought me in terms with things that I have not been wanting to confront to my self and it was helpful how other people were present as well to see that. I don't know, I think people were quite upset by it, I think, but I think it helped" (mother of Angelika)

The family sculpt though not perceived as powerful an exercise as the role play (which is perhaps symptomatic of the fact that it was salient for about only a quarter of the parents and just a couple of the patients) generated a fair amount of response. Most parents found it helpful in terms of actually presenting something like a picture of what the family was like also with the illness there while for one father it was a useful way of expressing the family's care and concern about their ill daughter.

"the statues, the family sculpt was useful in seeing how family members perceive themselves and anorexia so that was helpful, stood out" (mother of Nicole)

"the other thing which I thought was amazing is when you had to put your family around you as things are at the moment, like a picture with everyone standing there" (mother of Danae)

"there were a couple of sculptures done which were very useful. I think they were helpful for all the children not just for Samantha, to realise that their parents care very deeply and they try their best in whatever way to pull them out of this" (father of Lara)

As for the patients experience of the family sculpt one perceived the exercise as helpful and the other one as unhelpful.

"I think where we had to sculpt where each member of the family was and we had to use other people and just pretended they were being members of your family; I think that was quite helpful for everyone, to see how it feels with there having the family around" (Danae-patient)

"we did an exercise, I didn't do it, someone else did it but it affected everyone, you have to pick other people and play the part of the people in your family and then put them in a position of how you feel, like a family picture. It didn't do a lot and then we were all really drained and the person who was doing it, were quite upset so that wasn't very helpful" (Lisa-patient)

Time line & Family Tree

About half the parents commented positively on the time-line exercise and the family tree exercise indicating that it constituted, in an overall sense a positive experience for them and at the same time seemed to be activities with which their children were engaging

"the time line was very helpful. She threw herself into that, did a 3D time line which was amazing and I was just sat back and looking at her [...] and I thought: 'this is my old Marilia so that was helpful for her I'm sure, focusing the next year for her and made her think about her targets for the next year, that was good" (mother of Marilia)

"the time line was helpful, mainly because she did that lovely display that other people liked as well" (mother of Heidi)

"I think all the girls got quite animated doing the family trees and the time-lines, they wanted to really take part, if you did something wrong they were: 'oh no no that's not right' you know, this that and the other" (mother of Julia)

"the time line thing that we did was the best thing that we did because we did it as a family so that was quite helpful but it was very much us;Nicole did things, she did the writing and the drawing but she didn't actually put a lot of things herself but it was helpful because it made us look into the future. (mother) and I hadn't done that, all we talk about is Nicole, we talk about now, how do we increase her food intake. It was like taking a long term look at how things could turn around, at that time not knowing how close she was at being critical and admitted. It was helpful as a chance to think about what's coming up really" (father of Nicole)

For 2 of the mothers however the time line although helpful was also related with a sense of realisation of how seriously ill their daughters still were.

"I think trying to do the year plan was, well again, I don't know how useful Karen found it but I found it quite interesting to sit and talk about things that may or may not happen; although I think it also showed that Hannah is still very much in the grip of anorexia and the things she wants to happen are all the things we don't want to happen, like losing more weight" (mother of Karen)

"and then also the time line, I think we've all realised that it's going to take, it's not going to be fixed by Christmas. [...] I think we're rethinking about what our plans are going to be for Christmas and even our holiday booked for summer; again we realised

that that's not a definite plan, that might have to change. I think we now know that it's going to take time and accept that. That's hard actually to accept; it's weary" (mother of Artemis)

While for some of the parents the family tree was helpful in terms of rediscovering family strengths and support.

"I think when we did the family tree that made me see perhaps where the support would come from or perhaps where you should look for. Everyone is willing to give it really in the family I think but you have to ask for it" (mother of Artemis)

It is interesting how for one particular parental dyad both the family tree and time-line exercises played a significant role in their daughters understanding of the fact that she lives within a normal family which is similar to the rest of the families in the group. It is interesting however how the daughter herself makes no mention of this normalisation effect as indeed she is one of the few patients who did not comment upon this specific intervention at all.

"the tree was good because it showed that other families have problems with extended families i.e. grandparents, brothers and sisters and some people don't like each other and our family is no different as we saw from our family tree. So there was a benefit there for Jemma to see that she lives within a normal family, if there is such a thing" (father of Katerina)

"the time-line was important for me in the understanding that the problems that we're having and the interactions that go on or don't go on within the family, we're not that unusual, because you begin to think that you are" (mother of Katerina)

It is interesting however to note that although the parents found these exercises helpful in a variable way there was a great consensus amongst the patients who found the time line helpful as an opportunity to set themselves concrete goals for the year to come.

"and doing the time-line was helpful and looking forward to goals and see what could happen and apart from saying what you want to happen and never knowing that it will" (Nicholas-patient)

"the time-line was helpful; gave me something to work towards I suppose" (Katerina-patient)

"the time-line was very helpful I thought because you put things into perspective. Think about what needs to happen in the future in order to be back to normal" (Christine-patient)

"also, like in terms of the things when you look at your life over the next year and you look at where you want to be at. I found that really helpful. Things like, first where the weight goes. I really thought about that. I haven't really thought about that so much. All I thought was I want to be back but we were actually setting proper goals like 45kgs by half-term. Really made me think: 'well, I've got to'. You actually got targets and staff" (Angelika-Patient)

The patients' experience of the family tree come in stark contrast with their experience of the family line. There is consensus among the patients in the usefulness of the time-line with respect to putting things into perspective and setting goals for the future. On the other hand the children were near unanimous that there was little value in the family-tree exercise. In fact most of the children seem to find this exercises quite meaningless and cannot see the point of it; they also consider it to be completely irrelevant to their recovery from anorexia with one exception of a patient who revised her opinion as she was talking about the family tree maintaining though that the sharing of the family tree in the group was unhelpful.

"I found the family tree, I didn't get that, I didn't think that was of any point really [...] everyone that got up and explaining it, it got to some people, you know, looking back in time. I don't think there is a point really doing that, it's just upsetting people, I don't see the point" (Christine-patient)

"but the one think I didn't think it was so useful was the whole, when we had to draw up our family tree. Actually I said I don't think that was useful in terms of my anorexia. I didn't think it was useful in terms of a family, an actual family tree because we've discussed a lot about how our family works which isn't specifically relevant to anorexia so that didn't really make a difference but in a way it did. Kind of we were able to assess our family. But the sharing of the family trees, that wasn't so beneficial" (Angelika-patient)

Psycho-education

Some of the sample (7 parents and 2 patients) talked about the perceived effect of this intervention with most of the parents (4) perceiving it as something useful in terms of providing information.

" I found the instructions on the medical side of the illness very good" (father of Anabelle)

"also Carolain giving a different angle: this is what happens, this is anorexia if it goes on. In terms of information I think that was useful. I had no idea about what was going on" (father of Elena)

while for a mother the psycho-education was useful more in terms of observing the patients' reaction or lack of reaction to that information rather than in terms of information.

"and I think a good think, I mean I knew a lot of it anyway and I think some of the girls did as well, one of the doctors gave a talk about starvation and what it does to your body and you sort of think: 'if they listen to this it's scaring their parents to death' and even

though they're talking about all those horrible things that can happen to you, literally the worst thing that happens you die and all the girls could think about was the fact of how much fat there is in something; they were still so obsessed with that side of things than the actual risk of dying" (mother of Julia)

Nevertheless, 3 of the parents were not sure about the helpfulness of the psycho-educational talk on the grounds that although it is something that people need to know most of them do anyway so it is just scaring people more without providing the support and solution(s) they feel they needed following that sort of intensified information.

" I did know those effects and I didn't need really scaring anymore but maybe for those who didn't know it might have been useful but I felt gosh, well I'm scared enough and yes I'm really scared but now I'm going away. The implication being that we all needed scaring but hang on a minute, you can't just scare people and then dump them. I think some people may have found quite hard to deal with" (mother of Marilia)

Also, for those parents psycho-education constituted a return to the medical model and they were uncertain as to the usefulness of that given the group and psychosocial character of the MFG treatment. It is worth noting, however, that that those parents who were critical of the psycho-education, generally said that they were already aware of the information delivered and one of them concluded that not losing sight of the medical aspect of the illness is, after all, very important.

"I don't know where the medical talk, whether or not that was useful. Certainly wasn't for us but maybe for other families that haven't read or researched or been on the internet maybe that was useful but I don't think it was that helpful. It wasn't anything that we didn't know and for some reason it didn't fit for me into the context of the other sessions. The other sessions were very much group orientated, being facilitating, discussion based and suddenly we got a talk, medical model. Whether or not it could have been integrated more and made more interactive I don't know. Very useful in some ways,

but wasn't sure about that for us anyway. It might have been useful for the other people" (mother of Katerina)

Both of the patients who commented on the psycho-education found it helpful.

"it was also useful that we were told about anorexia and the dangers for your body by the doctor" (Artemis-patient)

"quite nice to hear the doctor explaining like a textbook, you know, you read them in a paper or a book but it's not quite as good as a person discussing what the effects are with you because reading it you're: 'oh yeah, fair enough there are things that could happen to me' because you're reading them and it's not like: 'this is what you will have' but then putting up a picture with the bones and teeth you're like: 'oh my god I don't want this'" (Nicholas- patient)

d) MFT climate & environment.

The theme of the MFG climate and environment emerged from the respondents discourse on the interaction between group members (including both families and professionals) and how these interactions facilitated group, individual and family processes. It is interesting to note that this category encompasses both a practical and an emotional component and that although a substantial proportion of parents talked about this theme none of the patients referred to it. The sub-themes that emerged within this MFG processes category and which will be examined in more detail in the following sections were: Group members mixing well, confidence in the clinical team, and time and space. Nearly all the parents who talked about the above sub-themes only referred to them in a positive manner. The one exception was a parental couple who were clearly dissatisfied with some aspects of how the group was conducted and the relevant involvement of the clinical team.

Group members mixing well

Our clinical experience has demonstrated that people are usually rather apprehensive when first offered the treatment option of the MFG. This is not surprising given that it involves the sharing of difficult experiences with a group of people who they have never met before. It is therefore all the more striking that most of them referred to a sense of the group mixing well together and group members getting on well.

> *"I think the group actually jelled very well and lots of the discussions were very useful" (mother of Katerina)*
>
> *" and actually the people we've been with are really nice people so we sort of got on really well" (mother of Christine)*
>
> *"it was really really nice families and we jelled well, I felt" (father of Nicole)*

The parents' sense of mixing and getting on well with the other parents is of particular importance given the fact that indeed each group is formed by a number of participating families all of which are different from each other in terms of background, personality, stage of their child's illness, experiences of previous treatment and socio-economic status. Sometimes this was specifically acknowledged by parents for whom the common goal of helping their children was an underlying factor of those positive group dynamics.

> *"4 families that never met before seemed to gelled with the staff so there wasn't any, I noticed, there's something that I note from my own profession, there was nobody cast outside. Nobody, no member of staff that had got an attitude or anything so it jelled from the word go. It was like a huge support network, the professionals and just ordinary people. So you know, quite a lot of that was very useful" (mother of Nicholas)*
>
> *" we had a good choice, mixed backgrounds and that was good" (mother of Nicole)*

"it definitely was a good mixture, despite all of us being from different backgrounds really" (mother of Marilia)

"the group is made of each one of us and we haven't met before and each of us have our own personality. Generally the one helpful thing is we were all there to help our children" (father of Lara)

Also quite a lot of the parents commented on how the good climate between the families was related to the parents' communication, participation and freedom of expression during the MFT group.

"In a group there are people who are going to contribute and there are people who are going to listen but listening is a contribution. I don't think anyone is, it's not a group where one person has taken it over, you know. It think there were 3 or 4 strong people in there who, but also in their own way there're other people who've contributed as much just by being the honest ones, by making the odd comment, I suppose it's worked quite well" (father of Athena)

"I think it was a good group. I don't know what they're usually like but I think it was a good group. There was quite a lot of interaction between people and people weren't upset to say anything or to say anything that might upset somebody which I think it's really good. I think people were saying what they thought which is brilliant and came up with some really good things. I think it was a really good group" (mother of Heidi)

"Everybody seemed to have participated. I got the impression that everyone was feeling comfortable in speaking and taking part in the various, uhm, I can't say that there was something in the group that I got the impression was unhelpful" (mother of Artemis)

Participants themselves, at times seemed surprised at how well they got on with the other families.

"I mean I don't know if it is normal for the group to relate so well but ours was actually. I think it bonds quite well and all the little interactions and things we've done it's been quite helpful" (mother of Christine)

"I was surprised at how we all got on, bonded would probably be a strong word, but I mean we all found it quite easy to talk, you know, there was always, I'm one of those people who always wait for somebody else to say something and then joining in" (mother of Julia)

Confidence in the clinical team

Parents seem to have developed a sense of trust and confidence in the clinical team with some of them relating it to previous treatment experience(s) they had had.

"as much as the LL (hospital) because although LL have done a lot of good they didn't have the knowledge or they didn't have, there was all different types of disorders in that unit and here they're dealing with people with the same thing and we need help we can cry help to [therapist] and staff" (stepfather of Lisa)

" I mean before, the dietician in the hospital, I mean they're lovely people and they are doing a great job with nutrition but you know we needed something that only an expert would be able to give us" (mother of Daphne)

"knowing that somebody is actually caring and doing in a certain way. I suppose last year in the hospital, it was very much a medical ward. You had a clinical psychologist who didn't knew, didn't deal with eating disorders so although there was support and they were helpful and, you know, there wasn't any feel that we're getting somewhere, we're going somewhere, we're gonna get to the end of this. Whereas because this is actually a unit that, you know, everyone's dealing with the same thing, you're not dealing with cancer on the one hand, with something else on the other, you are literally the core centre of eating disorders so it's helpful to know you've got this support and this back up and it was helpful to work for the 4 days" (mother of Nicholas)

Some of the parents also referred to the multidisciplinary nature of the team and the usefulness of addressing the different aspects of the illness by a variety of professionals involved in the group.

"and I think (nurse) from the ward; I think that was quite interesting to see how she went about dealing with [patient in the group] which wasn't meant to be part of it at all. Specifically Elena's eating times were so long in my view. So it's not just like, it's not just about encouragement and support but when it comes down to what we do as parents a bit clearer" (father of Elena)

"and having access to all the different professional people who were there. And it was very helpful having there, I forgot her name, the girl who's a nurse on the ward at the Bethlem. Hearing other people's perspectives who were involved in anorexia in different ways: someone who's a nurse, someone who's a family therapist, someone who's a doctor; all of that was quite useful. In the breaks in particular they would help you devise strategies for dealing with it in a day to day level which we didn't feel at the time that we got here necessarily in these groups with (individual family therapist). Because it was very much, not lacking, but there wasn't very much practical advice about what we do and I know why, I know why but even so it was helpful to have people say have you tried this, have you tried this which was very much what we were looking for at that time; we were very lost, very very lost" (mother of Elena)

While some of the parents also talked about specific instances of difficulty in which some of the professionals involved have been useful as well as their overall positive experience regarding how the group was conducted by the professionals involved.

"it was very very difficult and we weren't getting anywhere and I went inside and said to [therapist] and everybody, two of them came out and they were brilliant and it was because at that point I think they'd come out and they were just so good" (mother of Danae)

"with the groups, the family groups and with [therapist] as well, I think, I'm sort of

happy that we are, you know, that we, everything is being done, you know, there's no problem there" (father of Christine)

"I thought there was a variety of methods used and they were all very helpful. They gave different perspectives, different insights, you know, which is well done" (mother of Marilia)

"and I mean we were lucky about [therapist] being there and chipped in and told us different things to expect, different things to look out for and that in itself was a great help" (mother of Lara)

As noted earlier in this section although all the parents who talked about the MFG environment only referred to associated positive experiences there was one parental couple who was overtly critical of some aspects of how the group was managed and conducted by the clinical team. The mother seemed to be quite dissatisfied with, and intimidated, by the clinicians reference of themselves as the "professionals"

"I didn't like they were saying: "we're professionals, you're not professionals. Ok, you're professionals in your field, it doesn't mean we're not professionals, you know, two teachers there particularly didn't like being called non professionals, it's a very belittling phrase; I'm aware they are professionals in their particular fields and it was good having a mixture there but still parents were professionals as well" (mother of Nicole)

The father was quite critical of the perceived lack of adherence to the MFG's original timetable as he thought that this had negative effects upon both his daughter as well as the family's arrangement of when the patient's sibling was going to attend.

*"**E.S:** How about things that weren't helpful for Nicole(patient)? Did specific things happened during the MFG that you thought were unhelpful for Nicole?*
***Dad:** I thought, I know the program isn't rigid but there shouldn't have been a program because we were: 'oh, we're doing this today' and we weren't.*

E.S: *Could you possibly give me some examples?*

Dad: *Ahh, she would actually look at the program and ask: 'what do you think this means?' and then be told: 'actually we did that the day before'. It was difficult looking at the program to decide when to bring her sister, initially we thought day 1 and day 4 would be the best and because we didn't follow the program that was not a good idea and it was difficult having [younger sister] there for the last day because it was so not for her and she was getting irritated (father of Nicole)*

Also the same father in two distinct passages expressed his dissatisfaction with the clinical team and the way they were managing the MFG days. Similar to his wife he also makes an indirect reference to the clinicians' reference to themselves as the "professionals" while at the same time expressing his opinion about the lack of professionalism on behalf of the clinical team and his associated disappointment.

also it started 40 minutes late and that's all right people arrived late but why they can't get a room ready in 40 minutes? Why you go into a room and the chair's aren't out? Why can't you work out if the overhead projector works? And they are the professionals? They're not professionals, end of day (father of Nicole)

And the get, they meet after lunch and they've had half an hour of being together talking and we go into the afternoon session and they sit there and they go: 'we're going to split up now, who's going to go with who, you go with or no no you go with' and then you're thinking: 'you've had an hour and a half together and now you're deciding who's going to go with who?' You know, not professional, and you get things like that, you know, let downs" (father of Nicole)

Time and Space

Another theme that emerged was that the MFT group provided the time and space the families' felt they needed to have in order to be in a better position to deal with their child's illness. About one third of the parents referred to the time and space theme with some of

them commenting upon the usefulness of the day hospital nature of the treatment. In other words the intensive nature of the treatment taking place over 4 consecutive full days was perceived by some of the parents as providing a unique opportunity to take a step back and focus on their child's illness uninterrupted.

"and it was helpful to work for the 4 days. It was intense and as things came up you could then discuss them" (mother of Nicholas)

*"**E.S:** Did specific things happened during the MFG that you thought were helpful for you and [husband] as parents and for your family?"*
***Mum:** Ahh, the fact that it was concentrated.*
***E.S:** In terms of time?*
***Mum:** It was concentrated in that it was 4 days solidly" (mother of Danae)*

"and there is also an opportunity, you know, to get some, although [wife] and I would talk about it it's a structured way, setting aside days where there is nothing else to do but to talk about it and that's quite good as well. You know, actually focuses a defined piece of time where what you're going to do is talk about one particular thing rather than think: 'well, I've got half an hour' and then the phone goes on or something comes up you've got to do in the home or the garden, go to work. You know, it does focus some time to do nothing else but to think about that which I think was helpful as well" (father of Athena)

The above examples illustrate the parents' perception of the opportunities occurring during the MFG. Nevertheless, the parents also talked about the usefulness of the MFG in terms of offering a containing space facilitating the expression of feelings between family members that would probably not be expressed otherwise. These relate to feelings about the illness, as well as conflicting views between the parents.

"my niece came and she felt very very uncomfortable with how openly we were talking about how resentful we felt about it (the illness) and she very much felt as if Elena was

being attacked by people expressing those feelings. But I feel in terms of the family that's helpful too; being in a sort of safe environment where you can express those fears, angers and resentments (mother of Elena)

"and, uhm, just being able to articulate in a group certain things. My own view being at odds with [wife], so,etimes gives you an opportunity to say things that you wouldn't say at home. Like [wife] being a bit soft and things not going the way she thought they'd be going. Sometimes it's not the right environment seen being at odds with each other. (father of Elena)

For one of the mothers the MFG environment was also useful in making her daughter listen to what was being said including her mother's perspective as well as other parents' perspective with this also having an effect and bringing about change in how mother and daughter were dealing at home with food related issues.

"I think it also gives the child time to listen and the parents time to listen as well, in a home situation usually it's very fraught and children being children anyway without this don't want to listen, especially the parents, so in that kind of setting there is no choice but for them to sit and listen not just what I had to say but to what everybody had to say [...]I suppose as well while we were there, I mean all you're talking all of the time is basically food so I suppose just discussing the whole thing with people I was coming up with ideas of what to do for my situation, uhm, and being able to voice them and Daphne to actually listen and go home and follow them through which in normal circumstances, it all sounds easy peasy doesn't it, but it's not " (mother of Daphne)

Another mother talked quite extensively about the group setting facilitating the expression of her feelings about the effect of anorexia on herself and the family and she commented on the usefulness of that with respect of her daughter having access to feelings that mum, in an attempt to protect her daughter, would not have expressed directly to her.

" it has been helpful for me because it means that Elena, even if she can't, she won't always express it or I won't necessarily talk in that way one to one with her I would express it in front of her with other people present so maybe she gets to hear things that she wouldn't have heard otherwise because normally I would have protected her [...] it's almost like the ability to express things in a group which be very, would make for a very difficult and probably very short conversation once in a while. So it' s exposure to the different feelings and about how other people, the girls themselves didn't express anything much, but the parents did and I don't think it does the girls any harm to hear that [...] It hasn't diminished any of the feelings and it hasn't taken anything away but it has lead to an increased understanding perhaps so that must be a benefit probably. I think that's it really. It's just about her (patient) having access to a level of my thinking that she wouldn't normally have" (mother of Elena).

Sharing experiences and comparing notes

A central process taking place within the MFG environment as reported by most parents and under half of the patients was the sharing of experiences and exchange of information between the families.

Many of the parents talked about how the MFT group had enabled them to compare and exchange strategies as well as get new ideas on managing and coping with their child's illness. In that instance there is a sense on behalf if their parents that they're leaving the group with more skills and ideas, in other words with more tools in their baskets as to how to handle the illness at home.

"...and for adults it's helped because each one could give tips to each other about how to cope and how to move on."(father of Katerina)

"...Uhm, it kind of gave us new options and ways of dealing with the pressures and things like that and lots of people came with lots of ideas [...] various different families and how they've dealt with the problems and then I think we've all gone away and taken

what the other people have said, hopefully used it in a very positive manner."(father of Christine)

"Uhm, Yeah. I think again listening to the experiences of other families and hearing about how they dealt with situations. Like that one family who had just said we'll just do what we were going to do what we were going to do anyway and we won't let anorexia prevent us from doing things that we want to do. And that was quite helpful to keep in mind even if you can't always follow it. You think 'well they'd found that helpful'. So that sort of thing was helpful." (father of Artemis)

During this interaction of sharing and exchanging tips and information parents also acknowledged the different perspectives other families had depending on their child's length and manifestation of the illness. With this respect parents talked about feeling understood and knowing what to expect. Parents acknowledged that anorexia affected each young person differently but also that there were similarities between them, which meant strategies another family had used could be applied, avoided, or applied differently with their own children.

"... and people were coming from very different positions. There was a family who's daughter (had) only been ill for two months. Then the other two families, the daughters have been ill for a lot longer, uhm, so. Coming from different positions but I think uhm finding out that we actually had an awful lot of similarities as well. I think just getting more idea about how parents can cope, I think, yeah" (mother of Julia)

"...obviously each family has their slightly different angle on it and their child is at a different stage of recovery, but I thought it wasn't unhelpful to hear about somebody dealing with a problem because we were all 'well hang on a minute, that could be us next month, we may have this sort of thing to deal with' so I don't think anything was unhelpful." (mother of Anabelle)

"Uhm, yeah I think it was good to be able to share our experiences and obviously they

were all based around the central theme but they were all very different because our children are all very different, they're reacting in different ways, the take different personalities, they all exhibit their kind of reluctance to eat in different ways but it was good to kind of learn from other parents ways they have adopted to kind of tackle their problems and it, uhm, then challenges you to think for yourself, you may not do the exact same thing but try to think of a way to tackle that problem, uhm, within your own sort of family..."(mother of Marilia)

The exchange of information between parents is underlined by a constant process of comparison as to how their child is doing compared to other patients as well as how they, as parents, manage compared to other families. The therapeutic effects of this process seem to be enhanced by the apparent sense of relatedness between the parents possibly enhanced by the feeling of support discussed in an earlier section of this chapter.

"... it's good to get back and see how other people are doing to see 'is she better?', 'is she worse?' or 'is she more positive?' so whatever your position you can compare and you can see how it is all happening so you know that's about it really."(mother of Daphne)

" it's interesting to see sort of how other people cope with things that they do uhm as opposed to things that you've tried, sharing experiences was quite good. So that's been quite useful. So I think it makes you think about listening to other people's experiences make uhm flat up pitfalls for you flag up opportunities for you." (father of Athena)

"You identify more with some parents than others and there are some people you feel quite envious you know you think 'they've got somewhere' so you're thinking 'I want to get there'."(father of Anabelle)

" you can compare and then you know they have a general understanding of what you're going through because it's so horrendous and traumatic so at least other people going through it and say 'how do you handle it?' or 'do they do this?' and 'do they do that?' and you say 'oh yes exactly the same [...] and being with the other parents and seeing how they're coping because then you can relate to or you can say 'well okay they do that

or that family does that' and then you can sort of compare how you are handling it as to how they are handling it and see if you can get anything out of it, you know." (mother of Katerina)

All of the patients who commented upon this aspect of the treatment viewed it positively mainly with respect to the perceived helpfulness for their parents in dealing with the various challenging situations.

" I think it was helpful for the parents as well because they got to meet other parents and learn quite a lot of things from them and understand more things about the eating disorder and the parents talk about ways of coping with it and share ways."(Angelika-patient)

"And also I think Mum found out how other people were finding it hard to cope with the food issues and dealing with them and especially when one of them is a doctor." (Nicholas patient)

" I think they've learned from the other parents and also got the support"(Julia- patient)

7.3: PERCEIVED CHANGES IN THE PATIENT AND THE FAMILY

a) Perceived Changes in the Patient.

Outcome

About half the parents and a couple of the children commented on the perceived effect of the MFT group upon the patients' symptoms and/or illness related behaviour. With this respect most of the parents acknowledge that there hasn't been any significant improvement in their child's eating and weight as an immediate result of the treatment while in some cases the parents observed their child getting worse either in terms of weight or in terms of emotional and behavioural aspects. Nevertheless these parents acknowledge the usefulness of the treatment for them as parents.

"After that (MFT) Heidi got worst. Her anorexia got worse and afterwards we had lots of problems, because by that time we were at a stage where she had a meal plan-3.000 calories- when we started and after that she was: "well , I'm eating more than the other girls and I don't need to eat that much because I'm already eating more". And we had a real fight to get her back to the meal plan. And her anorexia was really bad and her she was upset, started hyperventilating again, started crying again for about 2 weeks after. So I wasn't sure whether that was good or bad really. I don't think she's got a lot out of it but I've found it useful." (mother of Heidi)

"cause even here today she seems to be, she definitely is much quieter and more shut down uhm, than say at home although she's become very very quiet and withdrawn. But I think when she's here it's that fear of getting better is closer, you know, we're already dealing with it, you know. Uhm, I suppose in time we'll find, we'll see things that were beneficial." (mother of Artemis)

Some of the parents, despite the lack of immediate improvement in their child's weight, appear to appreciate changes that took place, as a result of the MFT, in other areas of the patient's life and/or emotional/relational aspects. These are seen by the parents as equally important and also representing a first step towards a more significant improvement that will eventually include weight gain etc.

"I think on the whole Christine is responding, you know, I think she thinks that she wants to get better and it gave her a lot of encouragement. I think now, she's determined, I mean she says that she's determined to get better, uhm, so there is like one side of her that she's determined to get better but there's still that other side of her which says "I can't get better" you know, that's the problem, so I think that's a significant step, we've got, you now, she's definitely on the one hand which is positive think, so at least we've got one side which is on the right track, now we can sort of, we've isolated if you like the bad side of her and I suppose the objective now is to get to grips with that bad side of her and I think that came out very much did come out form the family sessions, I think that is something that did come out." (father of Christine)

Uhm, [fellow-patient's] family, hopefully it's helped them, I don't know, [fellow-patient] like Nicole, they are so strong willed and so determined they're not going to eat or they're not going to do what they need to do so it hasn't changed them. On Thursday it was a group day and it was [wife's] birthday and she didn't want to cause a rash so she ate, not much but she ate without fuss and we were able to get a lunchtime down at Camberwell, go to the shops, it was getting out of here which was nicer, uhm, and she ate just to go out and then she talked to those 2 friends at school about having anorexia and she did that so for us that was quite a step forward and I think she wouldn't have done that had she not been here." (father of Nicole)

One mother however while acknowledging the gaining of insight and understanding through the MFG is still expressing her worry and uncertainty as to whether this would eventually be related to and give rise into more significant improvements at the physical level of her child's health.

"I mean, that's it really. I think, uhm, I mean my concern is whether all this insight and understanding can be translated into recovery and so far Angelika actually lost some weight. I mean look at the chart, she's just above the critical level. Her BMI is, I mean, you know. I'm worrying all the time because she's trying to lead a normal life, a very active life, you know, but she's not, she's not in her normal state, so how long can she maintain it? Can she with all thins going on eat enough to gain weight? You know, it's not easy to do that. So that's it really." (mother of Angelika)

For another couple of the parents the improvement in the child's personality and attitude towards the illness, as well as the witnessing of significant improvement in other patients seems to have played a pivotal role in increasing these parents moral.

"I found it very very it was superb. Even though at the end of the group there was no improvement in Artemis. Originally we were hoping and praying that there is going to be

improvement but when we saw other people there we know it's going take time that kind of way. But we also know as well that it can be done with the results I personally saw and *the improvements I personally saw and I spoke to other parents at different stages and so on and so forth and I know it can be done." (father of Artemis)*

It is interesting here to note that the striking majority of the parents indicate an indirect effect of the MFG upon their children via themselves as parents. In other words, most parents believe that despite the lack of any specific symptom improvement in the patients the treatment was helpful for themselves, as parents, and as such had or would have an effect upon their children in due course.

"we have to change the way that she thinks; I think it's more for me, I know now that I've got to." (mother of Julia)

"E.S: From your point of view, has the MFG been helpful for Athena?
Mum: Yes, I'm not sure she'd admit that herself but I think because it was helpful to the parents the knock on effect would be on the child." (mother of Athena)

"E.S: How has that, in your view, been helpful for Elena? If it had.
Dad: Uhm, because it came for us as support. I mean Elena hated it, I mean she would never go back. Given the option she would not have attended that either. For Elena I think it's as much for our benefit." (father of Elena)

"So that (MFG) helped me and indirectly helped Nicholas" (mother of Nicholas)

Of the two patients who commented on the theme, one of them noted the improvements in all the patients attending the group, including her self, as well as its positive impact on her mother. The other patient, although acknowledging the helpfulness of the treatment in general terms is still unsure as to how much of her own psychological improvement is attributable to the group and how much to the fact that she is getting better.

" It was very beneficial. I think everybody made some steps forward. I certainly did, and, but also was quite interesting to see how everybody present, all the families made quite remarkable progress [...] And to see me (mum see patient) so much better from it. I mean that's obviously huge for the whole family. That's it really." (Marilia-patient)

"Yeah, it (MFG) was good but, I mean, there's not so many you can really say like "oh yeah, it's made a real difference because now I feel this because of it" I don't know how, like the feelings I have now, which ones are because I went to the group and which ones are just the normal process of getting well. It's difficult to say. Uhm, but I think, obviously I don't know but I do think it did helped a lot, uhm, just I don't know, some of the ideas." (Angelika-patient)

Realising the seriousness of the illness

About 1/5 of the parents talked with substantial relief about their children's observation of fellow-sufferers as increasing their understanding of how serious the condition was. For some of those parents the first step towards that was the acknowledgement by their child that she indeed was suffering from an eating disorder. This was seen as an important step towards the formation of an alliance between parents and their children in the fight against anorexia.

"I suppose the children know as well how bad this illness actually is and I thing of another thing as well, before Heidi actually went there she wouldn't have regarded herself as anorexic.
***E.S:** Is that a positive thing or not?*
***Mum:** Well, I think it is in that she recognises that it is an illness and it is something not very nice that she's got to get rid off" (mother of Heidi)*

" by day 3 she started to think that she may have a problem; up to then she hasn't got an eating disorder, we are the parents bringing her while it has nothing got to do with her. So she was very much blocking out everything that was being said but by day 3 yes, she was beginning to realise that she has a problem; that was helpful because you could not

do much without that" (mother of Nicole)

Along similar lines were the parents' accounts of their children's realisation of the seriousness of the illness and the potential grave consequences related to that. Quite often, this realisation is accompanied by feelings of shock and surprise on behalf of the children as perceived by their parents, along with a desire to get better in order to avoid being as ill as those other children are.

"I think it's been very helpful for Athena and I think the main thing that was helpful for Athena, one of the big shocks seeing the other girls that made her realise how serious it could get if she didn't do something[...] I mean seeing some of the girls, I think I remember saying the first day we came, she said to me in the car: 'I'm not as ill as those girls am I?'. I think she was very worried about especially, don't remember their names, about the girl who is in hospital who was looking very ill at the time and both the other girls as well. Athena was basically seeing herself as not being as ill as them, didn't want to be as ill as them so I think it was almost like a marker for her to see how it could end up if she didn't do something so I think that was quite useful. I think from Athena's point of view that was the main benefit out of it" (father of Athena)

"the fact that she saw some other girls that are obviously a lot worst than her and she, it made her realise that there is no way she could afford to be like that, you know, it made her think 'well, I definitely want to get better'" (father of Christine)

Overall, a key aspect of this theme is how, according to the parents, their children acknowledge their status as sufferers of a serious illness by observing the illness upon other fellow-patients.

b) Perceived Changes in the Parents.

Gaining insight into the illness

Some parents commented on how the MFT has facilitated their understanding of what the illness is about giving them thus a sense of insight and information about it. This was particularly evident at the two distinct levels of insight and understanding: insight as to the reality of the illness and insight as to how it feels for the patient. The first level was similar to the patients' acknowledgement of the seriousness of the illness, described above, and the second level also related to an increased sense of empathy with the patient.

This was a very significant theme for the parents as about three quarters of the group talked quite extensively about it. As for the patients, despite the small proportion of them who referred to this theme (about a quarter of the sample), those who did, seemed to acknowledge and appreciate this shift in their parents.

Insight into the reality of the illness

This theme is primarily concerned with the parents' realisation and/or understanding of what Anorexia Nervosa involves in terms of seriousness, time line, recovery and possible relapses. Although many of the parents had read and researched quite a lot about the condition, they claimed to have gained a more profound understanding of it, perhaps through the interaction with other families with a sufferer conveying information that is not conveyed through a book, article or even extensive conversations with professionals.

> *"it was helpful for my self as a parent really because before, you know, you read about anorexia, but you don't really know everything about it, so by going there (MFT) we know an awful lot about it" (mother of Heidi)*

"I think everybody got a bit more understanding about what's going on and some of the things they can and can't do about it; certainly the adults-the parents- I think they did" (mother of Karen)

The parents acknowledged this process of learning as it took place during the treatment context; this along with the more profound understanding was embraced by most parents as a helpful aspect with respect to information they gained. This was seen as facilitating their understanding of anorexia and in turn gave rise to an increased ability to cope with the reality of their child's illness along with the accompanying emotions.

"I think it's very useful; certainly to give me and other parents deep understanding of what anorexia is all about" (father of Lara)

"in general terms very informative, enlightened us to exactly what the disease is, the problems we were going to face, the long term prospects, the uncertainties. It gave us all that information, it was a benefit" (father of Katerina)

"I think everything has been positive. If you see other children as they are that helps us understand the problem, you know, I think everything, it's all about learning and I think in that respect it's helpful" (father of Christine)

"so the whole 4 days impacted on us and how we dealt and how we understand anorexia
***E.S:** Did specific things took place that you thought were helpful for you and for your family?*
***Mum:** Well, I think, same thing because it's all about trying to understand what's going on, that helped us to be able to cope more with the situation. I felt far more positive and strong, that helped me" (mother of Katerina)*

Some of the parents who commented upon gaining an understanding of the reality of anorexia as an illness, appeared to talk about their realisation of the slow and gradual process that recovery entails as well as the possibility of relapse(s).

" we'd like to jointly help Lara, but it's a process that can not be rushed, it's going to be very gradual" (father of Lara)

" there's quite inspirational things because it is an effort; it's not just about how it could be, it could be 2 years, it could be 3 years, it could be 4 years[...] there are times where you do see those improvements and you look for those times, you recognise those times but it's bound to be dips to these improvements [...] you pick on those incidents, you recognise them and say I don't want to go there, I don't want to be in [fellow-father's] position; still you know there is a possibility, it could go to 2, 3, 4, years" (father of Elena)

The parents' enlightenment with respect to the time of the illness seemed to have given rise to their realisation of recovery as a process rather than as a one-off event. This seemed to have encouraged realistic expectations and helped them to consider and possibly accommodate resultant changes in family plans.

"it does affect every part, the whole life changes. That has taken for a while to register, are you with me? I can see now how the whole life plan changes say with regard to the holiday, we might just have to cancel it" (father of Artemis)

"I must say it was a very good thing that we came because it made us to understand the illness, to understand what anorexia is [...] and we know what to expect and we know that it's going to take time because it's a long process so she will get better but it's a matter of time and patience. I know it's going to be hard but we'll beare it" (mother of Lara)

The above seemed to have also come as a relief to the small number of patients who commented upon it.

"it made my parents realise that this isn't something that is going to go away very quickly because I think that's what they thought; that they will get me to eating a bit and it will be on a roll, just take a couple of weeks and it will go away. I think it made them realise that it won't; it's going to be harder" (Katerina-patient)

Although the majority of the parents who commented upon this sort of gaining of insight talked about it in a positive way some other parents perceived it as a difficult yet helpful experience. This was due to the associated feelings of distress stemming from the realisation of how bad things could get. As the parents felt quite empowered to fight it, this realisation despite the associated distress, was eventually seen as helpful.

"they got us into 2 groups and you are talking to a couple of girls who'd been there and I couldn't believe this girl, she was 16 but she was 14 I think when it all started and she'd been in hospital twice and she was really really bad and she was so, I mean made me quite upset because she was so beautiful, wasn't she? you can't imagine her being ill and that's what, they sort of gave you the worst scenario and then quickly, you know, this is how it can be or how it will be, you know, it was quite helpful" (mother of Julia)

" uhm, well, I can't say unhelpful, the only thing I can say is that I found it quite distressing at times because of how ill some of the children looked, you know, and how sad we all looked as parents, you know, but I thing it's got to be a good thing.

***E.S:** In what sense?*

***Mum:** For moving things along. As I kept saying all the children are stuck in this awful awful habit, this routine that has got to be broken one way or another, you know" (mother of Daphne)*

One mother commenting upon her realisation of how ill her daughter was also strengthened by other group members' observations talks about how difficult that has been for her

especially due to the external observation. As there is no explicit reference to whether this was a helpful, unhelpful or revised experience, a rating of unsure was given.

" and also the other girls commented, [a fellow patient] commented, she graded on their way home in the car, you know, who she thought was the illest, you know, she put the 4 of them in order in terms of who was the illest and who was the less ill and you know, [other fellow-patient] was clearly the illest and then Elena, you know, and I find that, didn't like it really. I know it really but it's when somebody else observes it that you think, you know, because sometimes when you're at this stage, even now sometimes sort of hope it's all been a terrible nightmare and everything is going to be o.k but it's sort of that external reinforcer that things are very serious and it's just not going to go away and she isn't going to wake-up one morning feeling better and that she may well get worst or do other behaviours that are equally worrying, so yeah, it's not, yeah" (mother of Elena)

One of the mothers commented on the difficulty she experienced with how anorexia was portrayed in the group and how she found it rather unhelpful with respect to her dealing with her ill daughter, partly because of her own (mother's) beliefs regarding what anorexia is about not being in agreement with those of the rest of the group; also a reference made to mum's own coping strategies in cases of difficulty in life.

"my feeling because of how Joanna was and how violent she was, like I said I felt on my own. Uhm, uhm, I do feel that and I think it's probably because I hadn't got the complete understanding of this being enormous. I do think that it's slightly patronising to be anorexic because I'm one of those people where it happens and you pick yourself up and you dust yourself down and you get on with it. Whereas the way you talk to the children, it's hard to explain, again I think it's because I don't understand it solely as an illness and I think sometimes they need more of a kick sort of: "look hey" instead of this happens to you and I know you feel sheet and this happens to you"; It should be: "look hey, you are killing yourselves". It's like you don't get the urgency over to them of what they're doing and maybe that's just because I'm more of a firey person and because I'm more emotionally involved with Joanna because she's mine. But I don't think, I don't think, maybe they wouldn't get it on board anyway because they're not in that picture in

their minds because they, Joanna thought at the moment that she was actually fine and it was me that had the problem, so they might not take it on board. But I do feel that sometimes there're a bit sort of patronising" (mother of Joanna)

Empathy for the patient

Parents have also talked about an increased understanding regarding emotional and/or behavioural aspects of the illness and thus empathised and sympathised more with their ill child.

"it was hard work, it made me realise what she's going through as well" (mother of Heidi)

For some of the parents the feelings and attitudes around food, eating and recovery came as a big revelation further highlighting the emotional dimensions of the illness that go beyond weight, shape and dieting.

"I was glad to have been on the program because I feel I have learned so much more about the illness and understand more about it because initially when you hear about anorexia you think it's just a slimming thing, that it's just sort of something about not wanting to eat but you don't understand the fear of food, the fear of getting better" (mother of Artemis)

" I don't really think anyone's problem is the weight. I think the problem is, uhm, bursting into tears when you talk about food which can't be the right thing to do and while those things still continue there's still an issue" (father of Athena)

While for some of the parents some of the illness related behaviour, which was very puzzling, became apparent and appreciated as a further component of the illness rather than a strange and bad behaviour on behalf of their child.

"at one point everyone went away exhausted but to me it was an eye opener to see how the children were comparing themselves to each other and wondering who's fat, who's thin [...] so obviously there is a lot of competition going on; each one of them is watching what they're eating at lunchtime so that to me was absolutely amazing because they're thin as ticks yet they're comparing them selves wanting to lose more weight and thinking that the other ones are thinner than what they are. I would not have believed it if I had not seen it in action. I was told about this at St. George's but until you actually see this in action it's impossible to believe it. (father of Lara)

" to understand that the way Lara was reacting all the other children were doing the same thing, the same symptoms and you know, we are aware of that and also not to worry because it's the same thing that the other children are doing, you know, rebelling and screaming and shouting and back answering and doing all because they don't want to eat, so it's the same thing, so you know, we don't worry about that too much, as we were before" (mother of Lara)

The few children who commented upon that theme talked about an actual and observable change in their parents who, compared to how they were before, seemed to be more understanding and empathic of the difficulties the illness was imposing upon the patients.

"probably they got to understand it a bit more too whereas my mum probably didn't understand it that much before and probably understand more the things that I'm thinking; yeah, that's one of the big things that it probably did because it helped the parents to understand our point of view as well" (Heidi-patient)

"it was helpful for my mum to actually realise about anorexia. Before mum always thought like: 'what is anorexia? Ok stops you eating' but never actually realised that it' s something with you all the time constantly and made her think: 'oh my god how could you deal with that?" (Nicholas-patient)

Strengthening the parental dyad.

This category refers to the parents' perception of empowerment in their fight against anorexia and thereby promoting their child's recovery. The parents' determination not to give up along with a feeling of hope and optimism, in other words their sense of being able to "see light at the end of the tunnel" appeared to be of particular importance. Similarly, a sense of self- efficacy, that is, a feeling that they as parents are able to do it, as well as an increased sense of and permission to exercise their parental authority have been central themes as has been the improvement in relationship and communication regarding their struggles against anorexia. Each one of those themes within this main category (strengthening the parental dyad) will be examined in detail below. In terms of how the patients compare with their parents across this theme it has to be noted that most parents talked about all of the above levels while only about a quarter of the patients referred to any one of them.

Determination not to give up / feelings of hope and optimism

Most of the parents talked about developing a sense of determination and perseverance with respect to their efforts to help their child recover from anorexia even if, in some instances and for some families, these included occasional setbacks which would not however stop them from trying. For some of the parents, this came as a new insight while for others it was a reaffirmation of an already developed attitude. In any case, this sense of determination seemed to have been strengthened.

> *"we have to be persistent and we have to be louder and stronger than the anorexia which we tried on the weekend before [...] it didn't particularly work for Katerina but we are going to go back on that tactic in necessary although it's very hard work [...] we know we've got to be persistent" (father of Katerina)*

"Things helpful for us, uhm, I think we just got to persevere, persevere. Not that we've had any intention of giving up" (mother of Artemis)

"people like [fellow-parents] had shown that really you had to battle it through and also things like, to do things that you want to do and how to fall in line with that rather than we can't do anything; we have to make sure that Elena is all right" (father of Elena)

Some parents also talked about their determination not to give up in a sense of not giving up their hope and associated positive feelings as well as a sense that recovery is something that can actually be achieved. It is as if these parents, after having experienced strong feelings of hopelessness are now more able to see a possible light at the end of the tunnel.

"sometimes I feel quite hopeless, nothing's going to happen, she's not going to get better; but it taught me never to give up hope [...] the biggest thing was not to give up hope" (mother of Heidi)

For other parents, observing improvements in other patients was central to their sense of hope and confidence that things could eventually get better.

"seeing people who are well gives you hope. Sometimes on a bad day you think: 'it's going to be like that for the rest of our lives' you can't dwell on that too often; you've got to be positive with the child, yeah" (mother of Heidi)

"we also know as well that it can be done with the results I personally saw and the improvements I personally saw and spoke to other parents at different stages and so on and so forth and I know it can be done" (father of Artemis)

"from my point of view it was encouraging to see that certainly one of the girls was clearly getting better and that again for me is some encouragement because when we

came to the MFG or just before I was at a stage when where I couldn't imagine a time where she would ever be better. So the fact that there was a family who've been through similar very worrying times, not that it wasn't worrying anymore, of course it was, but their daughter was clearly getting better. Then I thought that was helpful" (mother of Elena)

For other parents hope and optimism is brought about simply by observing improvements in other patients; as if they are looking for small signs that would eventually restore their hope and confidence.

"gave me a lot of hope, seeing, especially seeing how frightened these 2 of the children were and have improved so much. Even seeing [other patient] who couldn't come on the Monday and Tuesday and the transformation by Friday was amazing. To see that by the end of the week gave me a tremendous amount of confidence because now I know that it can be done" (father of Artemis)

"it was good to watch one of the girls [other patient] you could see her change from the beginning to the end. She was very introverted in the beginning and at the end she was looking and observing and it was really nice seeing the difference. And it was really nice hearing [other patient] speak out because she was sitting very quietly but when she wants to say something she comes out and says it, yeah". (mother of Nicole)

For the few patients who referred to this theme it seemed to mainly involve a sense of parents becoming stronger.

"I think it was talking to the other parents, hearing their experiences; at first it frightened them a bit but then it helped them sort of be stronger, more determined to fight it" (Julia-patient)

Increased sense of Self-Efficacy

A theme related to the parents' determination not to give up hope and also to persevere in their efforts was their increased sense of self-efficacy. In other words, it was their gaining and/or regaining their belief and confidence in their own ability to help their child to recover. For some of the parents it was as if all that they needed was the support and reaffirmation, enhanced by the group, that what they were doing was right, the impression being that before the MFG they were tip-toeing as if on eggshells, not knowing whether what they were doing was going to be helpful to their child or whether it would make things worse.

> *"it's made us in a way think that we're doing the right thing; it's reassured us in what we were doing" (father of Athena)*
> *"it gave us confidence again, it gave us belief, you know" (father of Elena)*

For some other, possibly more demoralized parents, this sense of self-efficacy came more as a revelation to counteract their previous sense of incompetence in helping their child.

> *"just made you think: 'we're not getting it as wrong as we thought" (mother of Karen)*
> *"I thought maybe I was doing the wrong thing then but I suppose in the group they can tell you: 'no you're not doing the wrong thing, you're doing the right thing' but until somebody tell you" (mother of Heidi)*

Nonetheless, these parents appeared to have developed a sense of belief that they are adequate and good enough to care for their child and deal with the specific situations they were facing at home.

"the fact that we got involved in the course gave us I suppose a lot more confidence in how to handle the situations" (father of Elena)

"I don't really know how to describe this, I don't know how but we could somehow, we knew we could deal with her at home when we couldn't before" (father of Lisa)

"she's home again we know we'll look after her but it is hard" (father of Lisa)

Similarly, this increased sense of self-efficacy seemed to go hand in hand with the parents' increased moral as well as the understanding that it was them, as parents, who could eventually help their child to recover.

"you've got to be strong and have that will power to say; 'well I'm going to bit this thing and that's what I'm going to do' Well I think in that group actually, not just me, if you ask everyone there I think they are all going to say the same, they went away thinking to themselves: 'right, I'm going to do something about this' so you felt a bit stronger and more able to do it" (mother of Heidi)

"by and large though, I think yes there is support from family members but it's going to be us ultimately that get her better" (mother of Artemis)

Increased parental authority

A small number of the parents also talked about a sense of gaining permission through the MFT group and as a result of the interaction with other parents, to exercise their parental authority in order to deal with their child's illness.

"there were certain things that were said that gave us permission to do things if things got out of hand, like lock her in the room if necessary, if she was doing so much running around, strictly things like that [...] I think there were things that helped us, like I've said the fact that we could actually stop her from going out and exercising too much [...] there were things like, we knew ourselves ok but we didn't know how to stop" (father of

Lisa)

"the main thing that I got out of it was the being able to feel more in charge which I've not been able to do before for the simple reason Heidi just get so distressed" (mother of Heidi)

The children's views on increased parental authority where somewhat diverse with a couple of them perceiving it as something helpful for both the parents and themselves

" I think mum is a bit tougher now because before she'd give me a meal and I'd be able to leave some but now she makes me eat it all, I think that it is loads what she gives me; I know she knows that it isn't loads but now I have to eat it all" (Julia-patient)

" It's been helpful for them that other people have done things like locked doors to stop people doing exercise and things like that. I think mum and [step-father] felt that they couldn't do that, they thought, but coming to that (MFT) felt that they re allowed to; it wouldn't be classed as abusive it would be classed as helping, it wouldn't be something bad; because they've never hurt me they made sure they could be a lot more firmer. And it's also helpful for me because I know they're going to do that thing so I'm not going to try make them do that thing" (Lisa-patient)

For one patient the increased authority of her parents following the MFG was seen as having negative effects upon her own recovery due to the lack of acknowledgement of her individuality as a patient.

"it was forgotten that all the girls had like very different situations. You don't have it on the same line, you don't necessarily do the same thing and I think my parents adopted some strategies which maybe weren't beneficial to me. I started to feel less supported, quite pressurized, made things worst [...]my parents have adopted those strategies that they thought were right and they were very firm on them. They were adamantly stuck on to these strategies religiously because they thought that it would help me but it wasn't helping me but they thought that if they stuck to them, if they were really strict on them it

would help me and they didn't realize, they couldn't see that it wasn't helping me" (Katerina-patient)

Improved Relationships/Communication

The majority of parents referred to an improvement in how they were relating as a couple in their efforts to fight anorexia. This involved a realisation that it was going to be a joint effort as well as the fact that parents felt they were more in a position to talk about things together and in a more open manner.

"I think it helped [husband] and me to talk about things together and try and think about what we need to do. I mean if nothing else it's helped up to talk about what's going on a bit more" (mother of Karen)

"[husband] missed quite a lot of it but on the last day, I think he, and I'm still trying rather than me doing everything, uhm, to involve him a bit more. I know he wants to be involved, even the sort of like giving her her dinner and stuff like that, whereas before it was just, so trying to beat it as a family really" (mother of Julia)

"and the fact that [husband] and I, one big thing, it made us realise that we have to do it together because [husband's] out all day it's quite difficult. I felt when Danae came home I was trying to do most of it my self and one big thing I say now is: 'we have to make a joined decision on this because dad and I we both want to help you' it was just so helpful and now I say, you know: 'I have to have a word with dad and then we all think about it'
E.S: *About how you do things from now on?*
Mum: *Yes, and about when she asks: 'can I do such and such?' I think about it and then I get [husband] more involved, that's how I feel" (mother of Danae)*

One of the fathers specifically referred to his observation of an improvement in communication with his wife regarding their daughter's management as well as the empathy between the parents.

"the talking side of it. I came up with an idea, I mean last night I said to [wife]: 'this is a good idea'. We're talking about the situation instead of snapping out of it, than kind of thing [...] prior to the MFT we wouldn't basically sit and talk like that, we wouldn't have come up with an idea like that, are you with me? I'd probably suggest it and [wife] would say: 'don't be silly' that kind of way. So I've, we've definitely have more feeling for each other's feeling, that kind of way" (father of Artemis)

One of the mothers was very articulate about her perceptions of the MFT serving as an opportunity to improve the father-daughter relationship and rapport.

"for Angelika to have an opportunity to engage with both parents, you know, probably with father more, I think that was very helpful and very important. I think, uhm, you know, I think that for me that sort of a realisation that the father is very important on these dynamics and that something had gone a bit wrong on that relationship and it was a good opportunity to amend it. I don't think she quite realises how much he cares and how much it (anorexia) has upset him because he's got difficulty in showing it and expressing it" (mother of Angelika)

There was one example, however, of a very contrasting experience for one mother who perceived the MFT as pulling her and her husband apart (her husband had not taken part in the group). This woman was very aware of this contrast between herself and the other families who took part in the same MFT. She in fact contrasted her situation with her husband with the relationship of the mother quoted just above (mother of Angelika)with her husband.

"I think it seemed to be that all the other families, Angelika's dad was there, except [other patient], who's mum wasn't, it seemed it was pulling them together whereas we seemed to be growing apart with it; pushing us apart. Not so much Nicholas as much as [husband] and myself. Where it seemed to be pulling the other families together. That's what I noticed, they seemed to be mum and dad were separated but they would work together and also Angelika's mum and dad while me and [husband] are pushed apart.

That kind of stood out" (mother of Nicholas)

As for the patients, only a couple noted an improvement in the relational and communication climate of the family which was perceived as a helpful aspect for the entire family including the self.

"it's quite helpful that now if I ever get like this, mum and [step father] would stay and argue it out with me whereas before mum used to get very upset and cry and [step-father] used to just walk out" (Lisa-patient)

"it felt like a body to fight it together in the family, but we always do that, we always have been working together and talking and staff but it's just strengthened it" (Angelika-patient)

7..4: FUTURE DIRECTIONS: Some suggestions

This category refers to families' suggestions of ways to improve, or change, future Multi-family groups. Some families raised these suggestions when asked about aspects of the groups they found helpful or unhelpful. For other patients and parents these ideas were developed when asked what, if anything, they would have liked to be different about the group. The themes that emerged were mainly around the participants' wish for more separated sessions whereby young people and adults would have the chance to mix with their peers as well as the desire, especially on behalf of the patients, for more variety in the activities involved in the MFT group.

More parallel adult and adolescent groups

The more salient theme in terms of suggestions from both parents and young people was a desire for more time in parallel adult and adolescent groups. Some of the parents felt that it

was useful for the young people to have a chance to discuss things with people their own age and who share an understanding of their situation.

> *"I think it would have been nice for the young people perhaps to have more time together. They seemed to be saying they would quite like to spend a bit more time perhaps working on a few things together as a group; I think that's the only thing."(mother of Heidi)*
>
> *"I would have liked to see, definitely would have liked to see is that the patients themselves, the girls themselves being allowed to spend more time just on their own. Just let them, get them an hour or so, just draw. We want you to draw or do what you like; talk, draw, help each other out. There's bits and pieces like that but I suppose when you probably took them away from us, I suppose yeah (father of Artemis)*

While one father commented on the usefulness of the separated sessions also acknowledging his desire for the parents to receive some more feedback about what was taking place and/or being said during those sessions.

> *"I think the girls enjoyed going off a bit and having their own sessions. So we could get some more feedback. None of us knows how our child actually sees anorexia and doesn't articulate what anorexia means. It feels it has a voice but it doesn't have a person. Maybe that sort of feedback would be useful" (father of Athena)*

Most of the patients expressed the desire for more time with the young people without the presence of parents. Some of them, despite their uncertainty as to how, maintained their views that more separated groups would have been a beneficial and supportive interaction.

> ***ES:****"What would you like to have been different in the MFG? If anything?"*
>
> ***Young person****: "That there was more time for the young people to get together and talk." (Christine-patient)*

"I would like to have more time where it was just the girls both by having a counselor with us and also I'd suggest by ourselves to talk.

ES:*"How would that have been helpful?"*

Young person: *"I don't know, maybe by being supportive on each other, I don't know." (Heidi-patient)*

ES*: "What would you like to have been different in the MFT? If anything?*

Young person*: "More sessions with the girls talking without the adults being there.*

ES*: "Can you say a bit more about that? Would it be helpful?"*

Young person*: "I think so. Don't really know, not sure." (Elena-patient)*

Other patients had more specific views as to how more time with the young people would have been helpful including the fact that they found the interaction in small groups easier and less threatening.

ES:*: "What would you like to have been different in the MFG?"*

Young person: *"More one-to-one sessions."*

ES: *"When saying more one-to-one sessions do you mean individual families, or persons or young people?"*

Young person: *"One-to-one sessions us four [patients[with one professional or each one of us with one specialist."*

ES: *"Right okay can you say a bit more about that? Why would that be more helpful?"*

Young person: *"Don't like talking in groups." (Elena-patient)*

Some patients also felt that some of the activities, that were useful to parents were not useful for them.

"There should be more separate discussions and activities with the young people and one for the parents because some of the things they say aren't very helpful for the young

people. Even though I found discussions helpful, mostly, maybe some other young people would find other things more helpful, like artistic activities maybe they found them more helpful, so did I, more interesting."(Lara-patient)

More variety

Many of the young people suggested that they would have liked to have more variety in the activities they took part in during the MFG. More specifically they mentioned a preference for less discussion time.

ES: *"What would you like to have been different in the MFG? If anything."*
Young person: *"Uhm, probably it was a lot of the same thing really, doing the same thing in a different way, I think maybe it'd be better if it wasn't so much like that" (Anabelle-patient)*

ES: *"What would you like to have been different in the MFG? If anything."*
Young person: *"I think it would have been better if the girls have done a few more activities because it gets a bit boring sitting in that room, listening to everybody, sitting down for so long."(Danae-patient)*

ES: *"What would you like to have been different in the MFG? If anything."*
Young person: *"Uhm, probably it was a lot of the same thing really, doing the same thing in a different way, I think maybe it'd be better if it wasn't so much like that.' (Karen-patient)*

ES: *"What would you like to have been different in the MFG? If anything."*
Young person: *"I think it would have been better if the girls have done a few more activities because it gets a bit boring sitting in that room, listening to everybody, sitting down for so long."*
ES: *"So a few more activities target to the young people. What sort of activities?"*
Young person: *"I don't know what activities but just like colouring, everybody seemed to have liked that and forgot about it for a bit."(Julia-patient)*

ES:*"Yeah, that's okay. What would you like to have been different in the MFG? If anything"*

Young person: *"I think I would like to be more activity things rather than just discussion a lot of the time. Well you'd have an activity but it would go all the way round in a circle and talking." (Danae-patient)*

CHAPTER 8

DISCUSSION OF QUALITATIVE ANALYSES

8.1: DISCUSSION OF THE MAIN FINDINGS

This exploratory study aimed at gaining some insight into the patients' and families' MFT treatment experience by means of open-ended questions facilitating thus both reflection on behalf of the participants as well as free expression of their thoughts.

This open-ended method of enquiry seemed to have operated at two distinct yet interrelated levels. Firstly, by identifying aspects of the treatment perceived as having made an impact, in that that they were salient enough to be recalled and discussed; and secondly by understanding the function of the experience(s) in terms of their helpfulness/unhelpfulness.

With respect to the second level, that of helpfulness/unhelpfulness, it is worth noting that the differentiation between *positive/helpful* and *difficult yet helpful* experiences reflects a difference in process rather than the function of the associated treatment aspect. In other words, both *positive* and *difficult yet helpful* experiences are thought to represent overall helpful experiences and will thus be discussed as such. However, their helpfulness seems to have been achieved via a different emotional route with *difficult yet helpful* experiences also carrying a certain amount of distress whereas *positive* experiences were unequivocal.

Participants, (especially parents) although they were not directly asked about this, also talked about their feelings and expectations of the MFT before entering treatment. This suggests that expectations play a substantial role in the treatment process and should perhaps be explored more directly in future research.

The parents expressed their worries and scepticism about the group setting, its potential efficacy and/or lack of efficacy, along with the potential of "rocking the boat" and bringing about harmful rather than beneficial effects for their ill child. Parents were also sceptical about the group with respect to their own apprehension with such a setting; that is, involving a number of families and/or professionals with a private issue. Furthermore, the parents described extensively their underlying feelings of hopelessness, helplessness and desperation about their child's physical and psychological deterioration as well as of their sense of difficulty in coping with the situations and lack of appropriate treatment options.

In an overall sense, the MFT appeared to be perceived as a helpful treatment approach as indicated by the majority of associated helpful aspects reported. This is in stark contrast with previous findings from large scale surveys which indicated a great degree of dissatisfaction with treatment (Newton et al., 1993; Rosenvinge & Klusmeier, 2000), despite the therapeutic benefits achieved (Squire-Dehouck, 1993).

The results of this study are consistent though with more recent studies which indicated a fair degree of acceptability and satisfaction with family therapy (Krautter & Lock, 2004; Le Grange & Gelman, 1998) as well as with observations on MFT's acceptability and associated satisfaction in families with an anorexia nervosa teenager (Dare & Eisler, 2000; Scholz & Asen, 2001). This consistency however, might reflect the similarities between the specific models of family therapy used rather than being applicable to family therapy in general. This is possible, especially with respect to the Krautter & Lock (2004) study the family therapy model of which was the Maudsley model which, as noted in an earlier chapter, substantially resembles the MFT of this study, in terms of treatment goals and underlying theoretical background.

As for the negative/unhelpful experiences, their two distinguishing features are firstly their relative rarity among these families' discourse, as well as the lack of any single MFT process/ treatment aspect being primarily perceived as unhelpful by the majority of participants who attended. In other words, unhelpful experiences reflected a few individuals' difficulties with certain treatment aspects which were nevertheless perceived as helpful by most of the respondents.

Another interesting finding of this study was that parents were far more articulate about their treatment experience than the patients. Parents talked extensively, apart from their treatment expectations, about MFT processes including the *support network, specific interventions* as well as *MFT climate and environment*. They also talked about the perceived effect of the MFT in bringing about *changes* in both themselves, as a parental couple, as well as in their child. Parents also made some *suggestions* about future MFT groups. Patients on the other hand, talked mainly about MFT *support network* and *specific interventions* and *suggestions.* Very few of the patients talked about *changes* and this was only to the degree these were perceivable by and affected themselves. None of them referred to *treatment expectations* and/or *MFT climate and environment*.

The discrepancy between parents' and patients' degree of articulation might possibly be accounted for, at a cognitive level, by their age difference perhaps meaning that parents were more insightful and more equipped with the mental/emotional vocabulary that facilitated recall and discussion of treatment experiences.

The difference in articulation though, might also reflect that parents and patients enter treatment from a somewhat different position which in turn has an effect on how the treatment is perceived. This is clearly illustrated by the feelings of worry and desperation expressed by the parents when joining the MFT and the lack of expression of such, or indeed any other feelings and expectations on behalf of the patients. The *MFT climate and environment* can though be thought of as addressing those initial feelings. This probably reflects the fact that this category was developed by the parents' discourse only.

Similarly, most of the changes noted, occurred primarily within the parental dyad rather than the patient and mainly involved relational and emotional components of the parents' role, efficacy and strength as carers of their child. These might not have been easily observable to others outside the couple, including the young person. Hence the lack of substantial discourse on those *changes* by most patients unless it involved changes that had a direct, be it positive or negative effect upon the patient.

Furthermore, in an overall sense parents talked about the MFT's usefulness in addressing their own needs as parents and carers, rather than focusing on the needs of the patients alone. It is possible, that these parental needs and issues, although important, might not have been systematically and consistently addressed by other health professionals, who might focused on the child's anorexia in relative isolation. Given the potential novelty of this issue for the parents it is not surprising that the MFT's ability to do this stood out as particularly salient.

Patients on the other hand tended to refer more to their sense of isolation and the usefulness of the group in reducing those feelings as well as to the specific interventions of the MFT.

The former possibly represents a strong need of the patients themselves to interact with fellow-sufferers. It is also not surprising that specific interventions were quite salient for the patients. These were relatively intense and represented concrete, specific events taking place during the treatment rather than relational and environmental aspects of the treatment. This last point might explain why the experiences of specific interventions were recalled easily by the adolescent group.

It therefore emerges that the differing amount of recall and articulation between parents and patients might be accounted for by a combination of an age effect as well as differences in the need and position when entering treatment, between parents and patients.

A further interesting finding involves *suggestions* about aspects of the treatment that could have been different. Patients indicated that they would have preferred the group to have included *more variety* and activity oriented aspects and less discussions which often felt irrelevant and repetitive. They also suggested more *parallel adult adolescent groups* allowing patients to spend more time together in the absence of their parents. This second suggestion was also put forward by the parents. It emerges that patients felt to have benefited from the interaction with fellow-patients. The extensive, group discussions made little sense to the patients and seemed to be more parent oriented.

The parents and patients' suggestion for more parallel groups might be an indication of the fact that these provided an important opportunity for each sub-group to engage with their peers. At the same time there is a possibility that these sessions were less challenging than the whole group sessions. It is worth recalling the comments on this subject by Laquer et al (1964) who, while acknowledging the importance of peer support in MFT suggested that

sub-grouping in MFT *"yields too much narcissistic soliloquy [...] reflecting disinterest in the group and difficulty in establishing meaningful relatedness with other group members"*. However, a tendency for sub-grouping is something documented by other authors in the MFT field. For instance, Reiss & Costell (1977) in a study exploring patterns of interaction in an MFT held in an inpatient setting indicated that members do indeed split into parent and adolescent sub-groups. These were indicated by the sitting arrangements and were maintained throughout the life span of the group. Data on who-spoke-to-whom indicated limited interaction between parents and adolescents as parents tended to talk more to other parents and adolescents to adolescents. Therefore sub-grouping might be an unavoidable and often helpful tendency of participants within the MFT setting; given this tendency a certain degree of balance is needed so as not to eliminate the usefulness of some sub-grouping and separated sessions while still keeping the whole group together to maintain group cohesion.

8.2: HELPFUL EXPERIENCES: MFT Processes

What the participants in this study have described as helpful is quite consistent with earlier observations and clinical insights regarding both processes involved in MFT as well as fundamental aims of this treatment approach. Possibly the most significant features, involved the support network and the climate and environment developed during the MFT. The relative importance of these two inter-related features was demonstrated by a majority of the parents talking about these issues positively.

One of the most powerful descriptions involved the parents' discourse on finding a support network whereby they were understood by people in the same/similar position. This made

them feel less guilty and less isolated about their child's illness and the associated struggles. It also enabled them to give reciprocal support to other group members. These descriptions of the helpfulness and impact of a support network on parents and carers are similar to speculations about the therapeutic functions attributed to the MFT paradigm for eating disorders (Asen, 2002; Dare & Eisler, 2000; Scholz & Asen, 2001) and for other conditions including schizophrenia (Laqueur et al.,1964; McFarlane, 1993).

It is interesting here to note though that these families, although reporting feeling isolated and lacking appropriate support prior to the MFT, did not appear to be totally socially isolated. Most of them reported the availability of support coming from a variety of sources including extended family as well as friends, colleagues and sometimes other professionals involved with helping their child. Nevertheless, these sources were not perceived to be as helpful as fellow-parents, going through similar struggles; in other words it is what Asen (2002) has referred to as a "sense of solidarity" developing between these parents which seemed to have been crucial in their sense of both being supported in the here and now but also belonging to a network that could be activated, if needed, outside of the specific treatment context of the group.

What was also striking was the patients' rather astute understanding of and empathy with their parents' sense of loneliness, guilt and isolation and the corresponding acknowledgement that the MFT offered a forum for their parents to be supported. The need for mutual support was also described by the patients as one of their own needs, which were addressed during the MFT group and gave them the opportunity to meet and interact with fellow-patients.

It worth noting that peer support has been acknowledged as helpful and described quite extensively in both the MFT (Dare & Eisler, 2000) and group therapy literature (Lecker et al., 1973). Nevertheless, the adolescent patients' ability to understand and relate to the feelings of the older generation, as described above, within the MFT context has rarely been reflected in the relevant literature (Leichter & Schulman, 1974a).

On the other hand, parents did not appear to perceive that the MFGT group reduced their children's sense of isolation. This may be symptomatic of the fact that parents were more inclined to conceptualise the patients' need of support in a more generic way; by being in contact and developing a sense of rapport and identification with fellow-patients. In this respect most parents acknowledged the potential of these processes to help patients feel more supported. Whether they actually found the process helpful for their specific child however, rather depended on each parent's perceived outcome of the process.

Those parents anticipating benefits gained for their child by this interaction refer to its supportive nature; on the other hand parents who found that their child identified more with more ill patients (or that their child might have felt more normal and as such less inclined to change due to the interaction with fellow-patients) acknowledged the positive potential of this interaction but tended to believe that it did not work for their own child.

What was also very interesting was the fact that most parents believed that support and rapport processes did not develop, at least to a substantial extent, between the patients. This is quite surprising given that the majority of patients said how much they felt they benefited by those processes. This discrepancy in the perception of parents and patients might have

been reflecting a process that took place between patients during the MFG, but was, nevertheless, not anticipated by parents.

As noted above, equally significant for the parents was the climate and environment of the MFT. This theme reflected their thoughts on the interactions taking place between families as well as between families and staff and hence developing the climate of the MFT context. This seemed to be as important as the general support described above.

Despite the acknowledged diversity of each group parents felt that they got on well with other parents. This was something attributed to the fact that they were all working towards a common goal: to help their children get better. This finding is interesting given the plethora of indications and contraindications in the literature regarding the optimal composition of an MFT group.

Laquer (1976) argued for great diversity within families postulating that they should be as randomly selected and as heterogeneous as possible in order to facilitate exchange, identification and cohesion upon generic and universal areas rather than trivial commonalities. Bley (1981) on the other hand advocated homogeneity in terms of diagnosis and family structure (e.g. intact families, single parent families etc) but heterogeneity in terms of stages of illness and treatment. McFarlane (1982) called for homogeneity in level of patient functioning, age, family structure and diagnosis but diversity in socioeconomic level, race and ethnicity and stage of family life-cycle and coping styles.

The families in this study were relatively diverse in terms of family structure and socio-economic status, while patients shared a diagnosis of anorexia nervosa and were a similar age. While parents acknowledged their differences they appeared to also appreciate their

common problem and associated feelings as bringing them together and bridging their differences. The idea of identification based on shared feelings and experiences as over-riding external differences has been described in the MFT literature. As Leichter and Schulman postulated: *"as the group becomes more cohesive, identifications take place on the basis of universality of human emotions and needs, rather than on the basis of external similarities"(Leichter & Schulman, 1974b)*

Parents also talked about their increasing trust and confidence in the clinical team. In some instances they compared it to experience(s) of previous treatment(s) they had had. The clinical team involved in the MFT was seen as more specialised in treating eating disorders particularly for those parents whose children had previously been treated by G.Ps, CAMHS or general paediatric or adolescent mental health wards. The MFT team was also seen as able to address the multiplicity of issues encountered in anorexia nervosa while taking into account the wide spectrum of areas affected by the eating disorder, within the patient and the family. Parents said they benefited from the MFT which was able to offer them access to a variety of professionals involved in the treatment of eating disorders. The corresponding variety of perspectives and the multidisciplinary nature of the team were also seen as beneficial by the parents. Most of the parents did not refer negatively to previous experience(s); they seemed instead to perceive the MFT as a more comprehensive treatment approach. This was often accompanied by a sense of relief.

Another significant aspect of the group environment identified by the parents was the time and space offered by the MFT for both practical and emotional issues. The MFT context was perceived by parents as providing an environment where they could engage with each other with respect to their child's illness, uninterrupted by their everyday routine; which in

that instance, possibly due to the severity/seriousness of the illness tends to be perceived as an intrusion in their efforts to help their child.

The MFT context allowed freedom of expression while containing intense feelings encountered by families in distress, anorexia nervosa families included. The presence of other families, in the same position, facilitated expression and articulation of complex and painful thoughts and emotions. It provided an "audience" for these to be voiced out and shared while the person concerned could hear them as yet another group member. This helped reduce the confrontation found in a one to one discussion which, due to its sensitive and/or painful nature tended to be avoided altogether.

Lastly, most parents talked about the benefit of sharing and exchanging experiences and comparing notes with the other parents, about coping with and managing the disorder in the patient, along with all the other areas of life that are affected by an eating disorder. Some of the characteristics of these later comments relate to mechanisms of change in MFT. For instance, the fact that the MFT allowed information, expressions of feelings and multiple comparisons between and within the families does justice to Laquer's characterisation of the MFT as a *"sheltered workshop"*. Within this context Laquer (Laqueur et al., 1964) described a variety of mechanisms including *"learning by analogy" learning through identification and identification constellation"* and *"tuning in"*. These were believed to be vital for the therapeutic process and refer to the learning and gaining of insight via observation of and identification with other parents, patients and families as well as familiar situations.

As postulated by McFarlane (1982) the families' potential to learn about themselves by seeing part of themselves in others was a mechanism more significant to therapeutic change than the traditional insight, partly because it did not require issues to be stated and described in psychological terms increasing thus spontaneity and reducing potential threat.

Asen (2002) identified a further advantage of mutual observation and feedback between those families as it occurred during the MFT setting. This involved not only the similarities apparent to the group members but also their perceived differences and the associated curiosity which developed between the families as to how other families are coping. Related to this, was the introduction of new and multiple perspectives. This appears to be important for families of anorexics who can seem to be trapped inside distorted perceptions of their own family while being precise about other families. The same author also talked about the feedback coming from fellow parents as being viewed as more credible than that of professionals, due to the fact that families all share direct and quite painful experiences relating to their children's illness.

Overall, in this study, the parents' description of the MFT group as a forum of reciprocal exchange, facilitating discussion while providing a containing environment for learning and identification is consistent with the clinical depictions provided in the literature (Asen, 2002; Dare & Eisler, 2000; Detre et al., 1961; Laqueur et al., 1964; 1969; Laqueur, 1972; Leichter & Schulman, 1974b; O'Shea & Phelps, 1985; Scholz & Asen, 2001; Steinglass, 1998; Strelnick, 1977).

Similarly, what the parents have said in this study regarding the functions of the MFT group's support and environment is consistent with the feedback obtained by Lemmens and

colleagues (Lemmens et al., 2003b) by families in a series of multi-family discussion groups in a psychiatric day clinic. Here, the most important helpful aspects were found to be the experience of communality and capacity to help others, group cohesion and feeling understood, as well as appreciation and support. All of the above were also perceived to be beneficial mechanisms of the treatment not only from the point of view of the patients but also from the perspective of the therapists and observers who contributed their feedback regarding helpful aspect of the group in the Lemmens and colleague's (2003) study. Similar feedback was generated by another study conducted by Lemmens and colleagues (Lemmens et al., 2003a) for patients with chronic medical illness.

Another set of processes involved in the MFT that have been extensively discussed by parents and patients alike involved the *specific interventions* included in the treatment. These however, were characterised by a certain degree of divergence in terms of whether they were perceived as helpful or unhelpful. In this section the perceived helpfulness of these interventions will be discussed, while the unhelpful instances associated will be considered in a later section of this chapter.

The family lunch was found helpful by most parents and patients due to the supportive environment. It also gave the opportunity for challenging eating patterns while making use of the support coming from both parents and professionals. Even those parents and patients finding the lunch time extremely difficult in the beginning have acknowledged an eventual benefit.

The enactment exercises, (that is the family sculpt and role play) were of substantial salience for both parents and patients though many more participants referred to the role

play. In the role play exercise, the one striking feature governing all responses was its emotional intensity. It was this intensity that made the role play useful for most of the parents and patients either in the form of a positive or a difficult yet helpful experience. In that instance, participants have talked about the powerfulness of the role-play in helping them understand and experience the forcefulness of anorexia. As a result it made them more determined to fight it while for some other parents and patients it brought about a turning point for recovery.

The helpfulness of the family sculpt was for both parents and patients the fact that it offered a representation of family life with and without the illness as well as enabled participants to gain an outsider's gaze on the effect of the illness upon family relations and organization.

It is however interesting how these two, in principle similar interventions, made a somewhat different impact on the participants with the role play, in a sense, overshadowing the family sculpt as reflected both by its salience and experienced intensity. This might be accounted for by the thematic difference of the two interventions with the role play being around food, eating and the voice of anorexia while parents (and/or patients pretending to be the parents) were role-playing their efforts to feed their child (and/or parents pretending to be the anorexic adolescent). The family sculpt was on the other hand a mere representation of current family relationships, family togetherness and/or distancing and as such was possibly experienced as less challenging.

As for the time line and family tree exercises, most parents commented on them positively as they thought that their children engaged quite well with those activities; this is not surprising given the non-verbal nature of the activities as well as the fact that each family

kept to itself and was facilitated by only one member of staff while doing these activities before sharing them with the bigger group. Young people might have thus found the environment less threatening and intrusive and also did not have to elaborate in words. Parents also commented on the helpfulness of those two activities with respect to their own insight into the illness and how it affects the family members, family life as well as future plans.

Significant agreement was to be found in how the patients explained the function of the family tree and time line. The time line in that instance was seen as enabling them to set specific targets for the future; like an action plan which perhaps reflected a need of the patients who found themselves lost in the midst of anorexia not knowing where to start from, when thinking about recovery. The family tree on the other hand was perceived as unhelpful by all the patients who talked about it and will be discussed further in the following section of this chapter.

Finally, psycho-education on the effects of starvation, although rarely, was also mentioned to be helpful by a small number of patients and parents. For both groups this intervention was seen as useful in providing concrete, specific information while for the young people this had a further effect; that is to give them information in a way and within a context that enabled them to relate it to themselves and appreciate the dangerousness of the illness.

As noted above, most of the participants have talked about the treatments specific interventions at some point during their interview. This is in stark contrast to the results of Lemmens's (2003b) adult psychiatric patients, where these were only mentioned as helpful by the therapists and observers who found them as facilitating intensification in the group. The families in the Lemmens's study did not refer at all to specific interventions. This

respective difference might be accounted for by the different patient groups, both in terms of age and diagnosis, between this and the Lemmens study. As Minuchin and his colleagues (Minuchin et al.,1978) postulated, intense non-verbal and enactment interventions are necessary for the mobilization of resources in anorexia nervosa families. This however, might not be applicable to the general adult mental health population in the Lemmens study. Furthermore, the Lemmens group (2003a; b) did not enquire about unhelpful events in their treatment process it is thus not clear whether the lack of mention of specific interventions in their population reflects their lack of salience or the fact that they were salient enough but perceived as unhelpful. Nevertheless, these comparisons should be viewed with caution as Lemmens and colleagues did not specify the exact interventions employed in their treatment which makes comparisons with present findings problematic. A further difference between the present study and the results reported by Lemmens is that the latter did not involve intensive day groups but fortnightly meetings lasting about two hours.

So far the helpfulness of the support network and the group environment as well as that of specific interventions has been discussed as if each one of those constitutes a fundamentally different process. This distinction is a rather artificial one employed mainly for the purposes of clarity as well as in order not to collapse responses around different issues under one single category. Nevertheless, none of the above processes seemed to operate in isolation and independently of each other; they rather represent complementary and reciprocal processes the whole of which contributed to the uniqueness of the MFT setting. In other words, the establishment of a support network and the development of a containing environment facilitating freedom of expression, mutual comparisons and feedback can not be viewed independently of each other. Similarly, the helpfulness of specific interventions

whether through intensity, information, observation and/or verbal and non-verbal communication can not be taken outside of the context in which they occurred.

8.3) HELPFUL EXPERIENCES: Changes in the patient and the family

Overall most parents perceived the most changes attributable to the treatment and associated benefits to be taking place within themselves as parents rather than the treatment having a direct effect and significant improvement upon their child's symptoms. Indeed some of the parents even observed their child getting worse after the treatment yet this did not change their overall perception of the beneficial nature of the MFT.

Some of the parents, despite the lack of significant symptom improvement were satisfied by changes they have observed in their child in terms of him/her being more motivated to get better. This was perhaps associated with the fact that most parents have observed a significant shift in their child in acknowledging the illness, which was previously denied, as well as the patients' appreciation of how seriously anorexia can affect their physical and emotional health. If parents viewed the latter as a significant gain both for them and their children, it was seen as constituting a first step towards recovery and also facilitating the feeling that parents and child begun to unite against anorexia.

Along similar lines, parents talked about the MFT treatment as having an indirect helpful effect for their children through being helpful to them as parents. This suggests that the MFT is a rather parent oriented therapy. It is thus interesting to look into what parents perceived that had changed in them due to/during the MFT. The two main themes were the

increased understanding of the illness as well as a sense of the parents of being stronger in their role and as allies against the illness.

Parents talked extensively about their gaining of profound insight in to the condition, in terms of both the reality of the illness as well as also gaining some insight on how the illness is experienced by their child. This led to feelings of sympathy, empathy and understanding of the parents towards their child as well as more realistic expectations about recovery as a process affecting family life rather than as a one off event in time.
The sense of insight was closely linked to the interaction with other parents and patients giving a different dimension from the one the parents already had based on their own experiences with their ill child, and information on the illness they had acquired through reading, and discussing it with health professionals. It is interesting also how this process taking place within the parents was perceived and appreciated by a significant number of the young people, who felt more understood within their family context.

Overall the parents seemed to have felt that they were leaving the MFT equipped with more strength, power and determination to help their child recover from anorexia. Parents talked about feeling more empowered in their role and more able to exercise their role and parental authority in helping their child recover. This also involved an increase in confidence as well as their belief in their ability to be of help. Noteworthy was also the parents' description of a certain amount of improvement in the interactions and communication taking place within their family as well as in relation to the eating disorder.

As for the patients, only a few of them commented on the above changes taking place within their families. Some of the patients perceived the strengthening of their parents as helpful as it gave less opportunity for illness related behavior to take over.

These changes provide some insight into the participants' perceptions of how the MFT treatment benefited them on an intra-family level which was still viewed as relevant to the recovery process. It is worth considering now how these changes compare to those found in the MFT literature as well as relevant clinical experience and reports.

Partial denial of the illness is a common feature of anorexia nervosa, as noted in an introductory chapter of this thesis. Furthermore, clinical experience suggests that when families seek treatment it is usually the parents who bring their child into the services, often without the child's consent that usually maintains that there is nothing wrong with them and it is the parents who have the problem. Parents on the other hand can be intimidated by the illness and their perceived inability to be effective while anorexia is often viewed as something the 'patient is doing to the family'; parents often present to the services in despair hoping for a solution to come from the experts (i.e the nursing and medical staff). From the participants' feedback in this study, there appears to be a shift in that (so often encountered) dynamic. Patients are said to be at least more accepting of the fact that they suffer from a serious illness and are in need of help while parents seem not to localize the illness as within the patient only. Instead they seemed to appreciate how family life and their parenting had been organized by and/or around the illness.

Parents, instead of being intimidated in their role, dominated by feelings of hopelessness and guilt for the onset and maintenance of their child's illness and overpowered by

perceived worthlessness and ineffectiveness appear to be able to take a proactive stance. This might have a reciprocal relationship with the reported increase in their perceived self-efficacy and ability to exercise their role and authority as parents to assist their child's recovery. As for the noted improvement in communication between the parents, it is of particular importance in its own right but also as and indirect indication of the mobilization of resources as well as coping and problem solving processes within the family.

These observations are consistent with Dare and Eisler's (2000) accounts of previous MFT groups for patients with anorexia.

"A major emphasis in our treatment approach is to support families in rediscovering a belief in their own ability to help their child overcome her problems [...] day treatment has the advantages of keeping patients in their own milieu so that therapeutic changes are continually integrated into daily living and can address current family issues continuously"(Dare & Eisler, 2000; p.7).

Similarly, Asen (2002) indicated how the MFT for anorexia nervosa, through the direct involvement of the parents in an environment where professional staff are in a minority enables parents to "become expert themselves" instead of pursuing the belief that it is the professional staff, perceived as more able and more expert, that will provide the solution to their child's illness.

The present observations are also comparable to earlier speculations about the therapeutic aspects and potentials of the MFT in conditions other than eating disorders. Strelnick (1977) for instance, in a review of the MFT literature identified family involvement in the

treatment as well as improved communication and increased awareness of family interaction as central therapeutic components of MFT. Similarly, Steinglass (Steinglass, 1998) reporting on two separate MFT groups for kidney failure patients treated with haemodialisis noted that he found the treatment helpful in promoting within family communication as well as developing coping strategies. The issue of family communication and its enhancement through the MFT has also been noted by Anderson (1983) with respect to a psycho-educational MFT approach for patients with schizophrenia and their families.

These therapeutic changes lead to a rather important question: are they treatment processes or treatment aims and objectives? The often blurred boundaries between the two necessitate reference to a further distinction, this time involving mediating and ultimate goals. This distinction was originally drawn by Parloff (1976) from individual therapy and was later expanded to family therapy (Gurman, 1981). This conceptualization views mediating goals as steps which are necessary towards reaching ultimate goals and/or components of ultimate goals. As such mediating goals are manifested during the process of therapy and can also serve as markers of therapeutic change and progress; they can therefore be viewed as both means towards long-term objectives and as interim and temporary ends and achievements in their own right. Therefore, mediating goals are rather seen as aspects of the treatment process rather than as treatment goals per se. Ultimate goals on the other hand constitute criteria for termination of treatment.

In further extending this conceptualization so as to include MFT and the patients and families in this study it could be argued that ultimate treatment goals in that instance would be the restoration of the patients' weight, improvement of eating disorder psychopathology

as well as normal social and emotional functioning. Once these are restored then the patient and the family are no longer in need of treatment for the patient's anorexia.

The achievement of these outcomes has not been addressed in the present study but given the fact that the interviews were conducted between two and four weeks after the first five-day block of MFT an expectation of the patients' full or almost full symptomatic improvement would be unrealistic. What the participants, and especially the parents, talked about though refers to changes that were useful, to say the least, for the achievement of the treatment's ultimate goals. In other words, the patients' acknowledgement of illness and perhaps increased motivation to improve, are important starting points in any sort of intervention for any sort of condition. This is particularly important given the evidence that parental involvement is beneficial for the treatment of an eating disorder for young patients, while the exclusion of the parents significantly inhibits and/or delays recovery (Russell et al., 1987;1992).

8.4: ARE CHANGES ATTRIBUTABLE TO THE MFT?

In the sections above the helpful processes associated with the MFT have been discussed as well as corresponding changes as reported by the participants in this study. However, questions that follow involve the extent to which these are attributable to the MFT setting. As noted by various authors (Leichter et al., 1974b; O'Shea et al., 1985; Strelnick, 1977) aims and processes in MFT overlap with those of group and family therapy. Mutual support and feedback, sharing and exchanging of opinions are scarcely unique to the MFT setting as they constitute aims and processes thought to exist within group therapy (Kahn & Prestwood, 1954) while involving and making use of the family's resources, by restoring

parental roles, hierarchies and communication are among the fundamental aspects of family therapy (Minuchin, 1975; Minuchin et al., 1978; O'Shea & Phelps, 1985; Strelnick, 1977). It is therefore difficult to be specific about the cause of any of the reported benefits. Separate peer groups (parents' groups and patients' groups) might have been equally beneficial. Conversely, participants might have found individual family sessions just as useful.

The participants in this study described most of their experiences as involving both levels (group and family) with one facilitating the processes in the other. However, the material of the study precludes us from telling whether either form of the therapy (peer group or individual family therapy sessions) would have been equally effective in bringing about these perceived changes or even if the MFT has been effective in that respect, especially given the lack of a control group. Nevertheless, this attribution of causality of therapeutic changes goes beyond the purposes of the present qualitative exploration, the purpose of which was to gain some understanding of the participants' experiences. In respect to the previously mentioned distinction between mediating and ultimate treatment goals of therapy, this qualitative study can only be seen as looking into the possible mediating goals. A proper evaluation of patients' symptomatic outcome is needed to establish the effectiveness of MFT in that patient population. Similarly, although it is theoretically sound to speculate that the processes and changes identified by the parents do indeed play a role, that is mediate, the patients' treatment outcome, this is speculation only as this relationship is not empirically tested in this qualitative study.

Nevertheless, there are a few examples in the present data of how the presence of families enhanced the group effects of support. The experiences associated with the family lunch for

instance, involved the struggle of individual families being shared with the group. Similarly, learning from each other did not only involve identification with peers but also with whole families and specific family situations. As for the enhancement of family interactions by the presence of the group a rather representative example involved parents talking about being able to express difficult and "loaded" material involving their children and/or spouses that was said to be difficult to express in individual family therapy sessions. In this respect, it may be the case that MFT is not only an addition of its components whereby group and family processes work together and in parallel but also to represent a unique setting where group and family processes can operate in a synergistic manner one facilitating and enhancing the effects of the other.

Of particular relevance with this respect are Leichter and Schuman's (Leichter et al., 1974b) thoughts on MFT in relation to group and family therapy. They postulate that having a group of whole families with pre-existing rules, structure and mythology as well as current life/family situation is dynamically different from a peer group composed of strangers. At the intra-family level, in the MFT parents are seen by their children not only in their familial role but also as people interacting with other people. Young people are seen by their parents not only in their usual role of the "child" in the family but also as youth interacting with their peer group. In other words the authors while acknowledging the similarities between MFT and family and group therapy summarise MFT's uniqueness as:

"It is quite unusual in the ordinary life situations as well as in the therapeutic world, that families expose themselves to one another and try to have a significant effect on each other's way of life" (Leichter & Schulman, 1974; p. 109)

From what has been discussed so far it emerges that the generic goals and processes of the MFT are not distinctly and fundamentally different from those of family and group therapy. Rather it provides a setting where these can be combined in an interrelated manner. This is in agreement with suggestions put forward in by O'Shea & Phelps (1985) when reviewing the MFT literature; these are summarized in the following:

"the distinguishing feature of MFT may not be the uniqueness of its goals but rather the effectiveness and efficacy with which MFT achieves generic therapeutic objectives"

(O'Shea & Phelps, 1985; p.566)

This is not however to say that more research is not needed into what actually constitutes helpful processes within the MFT paradigm, particularly from the participants' perspective. Although this study has contributed to that, it did not directly addressed the issue through an adequate comparison; this could only be achieved by comparing families' MFT treatment experience with that associated with family and/or group therapy. This would highlight similarities and differences between the three, contributing thus to greater clarity and understanding of commonly and unique features of each treatment approach.

Furthermore, the processes and changes described above although quite consistent with findings and observations by other authors can not be easily generalized to all MFT approaches and for all patient populations. The perceptions of helpful aspects of this treatment which emerged in this study can only be seen as reflecting the experiences of this sample of families and anorexia nervosa patients that have undergone the MFT program as practiced in that particular setting.

Finally, despite the valuable insight on the participants' regarding what they found helpful, this can not be seen as reflecting the treatments' actual therapeutic ingredients. It is very difficult to know whether what is perceived by patients and their families as helpful is what actually makes the difference in the family and the patient. The feedback generated in that instance is rather useful in indicating aspects of the treatment that make sense to the families and as such can have implications for engaging them and actually keeping them in treatment which is a crucial matter. Furthermore, there is also a possibility that aspects of the treatment that were perceived as unhelpful might have also played a part in enabling change.

8.5) UNHELPFUL EXPERIENCES

Overall, a relatively small proportion of the sample indicated aspects of the MFT treatment as being associated with unhelpful experiences. These unhelpful experiences do not refer to treatment processes which are different from those seen as helpful by the majority of the participants and discussed above. Unhelpful experiences seem instead to represent a different dimension of the treatment processes as indicated by some of the participants. These experiences will be addressed in this section; they seem to reflect particular difficulties experienced by specific individuals rather than altogether negative aspects of the treatment. Finally, suggestions for dealing with potential similar difficulties within the clinical practice of MFT will be attempted.

Two parental dyads reported on unhelpful instances which related to the clinical team. One of them felt confused and intimidated when the team challenged them and their daughter regarding her calorific intake. The diet plan had been agreed previously between the family

and another clinician before joining the group. However, both parents felt they were struggling, yet managing to implement the instructions given to them. This meant that they perceived the team as being unfair to them. They also found the different messages put forward by the two different clinicians confusing. This episode represents a lack of appropriate communication between the previous clinicians and those of the MFT. It is often the case that more than one clinical team is involved or had been involved in the patient's care when joining the MFT and it is important that adequate communication is established. Similarly, families and clinicians should be both transparent and in mutual agreement as to the targets set in order for the families not to be caught between contradicting and confusing instructions.

The other parental couple found the team unhelpful in a completely different way. In this example the parents talked about the team's lack of competence in managing the organizational aspects of the group such as following the program, organizing the chairs and making sure the overhead projector worked properly in the psycho-educational talk. These parents also found the clinic's café unhelpful and the tea and coffee provided during the breaks unsatisfactory. The same parents were also intimidated by the clinicians referring to them selves as "the professionals". They felt this was not acknowledging the parents' role as professional people in their own right and in their own working environment.

It is quite interesting that other families did not pick-up any of these issues which were, in all probability, present for all of the MFT groups. It is possibly the case that within a busy clinical setting (as the one where the MFT groups were conducted) there is always room for improvement in terms of administration and organization; however, the amount of

discomfort this generated for these parents was unusual. For a family in the midst of a life threatening and disruptive condition like anorexia, most parents might find the organizational/administrative aspects of the treatment relatively trivial. One could speculate that for this parental couple the complaints about these issues, although probably fair, might have also been a way of distracting themselves from more difficult issues. They may also have felt that given their difficulties and struggles with their child's illness, the least a treatment program should have been able to offer was good administration, as a marker of their more general expertise.

Sometimes these parents are characterized by health care professionals as *difficult, irrational or uncooperative* which might be descriptively accurate for some families. A more empathic and constructive explanation, however, can be that these attitudes reflect attempts of a family to cope with very challenging and difficult situations including an eating disorder in the family. Even if this represents stable personality traits of some of these parents (though we can not automatically assume that) it is important that the treatment is flexible enough to both acknowledge and deal with their concerns, to enable them engage with the therapeutic process.

Another aspect of the treatment that two of the mothers found unhelpful involved their gaining of insight into the reality of their child's illness. For the first mother the realization that the illness could get even worse along with the feedback of other group members suggesting that her daughter was one of the most ill patients in the group were perceived as unhelpful despite the fact that she was aware of it herself. It was the corroboration by outsider observers that made it more difficult.

It is only natural that some parents will experience these feelings and it is important that they are contained and facilitated during the group. This could possibly be achieved by indeed explaining how, in most groups, there usually is a patient who is or seems to be more ill, without this though necessarily predicting that he/she will not get better. Similarly, the possibility of the illness getting worse should be acknowledged as one of the possibilities but not the only one as young patients who get help early on tend to recover. In other words, it is important that parents are appreciated for seeking and managing to get help for their child, while they are helped to manage their current state of uncertainty regarding whether he/she will eventually recover.

The other mother who found the insight into the illness unhelpful did soon the grounds that she could not identify and indeed be convinced by the way the rest of the group talked about the illness as being a force outside of the patient's control. She found that patronizing and would have preferred a more direct approach handing the responsibility to the patients of what they themselves are doing and how they should stop it and move on. This mother acknowledged that this was her own attitude to life and way of dealing with problems. In other words the atmosphere cultivated in the group regarding the illness and how it should be tackled was at odds with this mother's normal coping strategies. Although this rather pro-active way of coping might be one of the family resources it is probably not readily applicable for a patient suffering from anorexia. On the other hand, it might be worthwhile for the parents to be encouraged to use this attitude and try and take/exercise control over eating, only temporarily, until the child has actually the choice; that is, he/she is (at least partly) recovered from anorexia.

Regarding perceived changes in the parental dyad, one mother and one patient found these unhelpful as they applied/did not apply to their family.

For the mother the observation of other parental couples being closer and joining the group together and in a sense working together as a team despite the fact that some of them were separated, highlighted how apart she felt that she and her husband were growing. This instance rather reflects marital/couple difficulties becoming more evident through the group process and the interaction with other families. As discussed in the previous section the MFT groups are diverse across a variety of domains including family relations, composition and structure and as such it is always possible to have one or more participants who experience difficulties in the group processes due to their own marital/family situation. This might be particularly true for single parent families, families with weak parental alliances and/or families where only one of the parents is involved in the anorexic teenager's care. This is an area that will need consideration in future MFT groups.

For one of the patients, the fact that her parents adopted strategies about her eating during the group and were firm and united in trying to enforce them at home was perceived as unhelpful. The patient perceived this as a loss of individuality within the family and felt they did not acknowledge that she was different to other patients in the group.

A similar point was raised by few of the patients with respect to the lunchtime as it took place during the MFT group days which was mainly due to the adults (both parents and professionals) challenging and comparing them. These patients felt they were being watched all the time and also that they lost their sense of individuality; their defining characteristic was that of the "patient". The loss of individuality is a common theme between these patients and the one noted just above. However, these patients perceived the

specific intervention of lunchtime (a feature of the group) as unhelpful while the patient noted just above perceived the parents' behaviour inspired by the group, yet exercised at home, (i.e. a change in the parents) to be unhelpful.

With respect to the patients' difficulties encountered at lunch-time, Asen (2002) suggested that one of the advantages of the MFT in anorexia nervosa families is that professionals are in the minority reducing the feeling of constantly being watched. However, lunch-time seems to represent a time where, not surprisingly, the patients' difficulties and illness related behaviour were very evident leading thus to a sort of distinction between those who were "well" and those who were "ill". In that instance the "well" group comprising parents and professionals outweighed in numbers the "ill" group with this, possibly making the later group feel under surveillance. In other words these patients might have experienced the group presence during lunch as an intrusive sort of monitoring which is in contrast to the patients discussed in the previous section who found the group supportive during lunch. This might represent a difference in the patients' stage of illness and/or temperament and disposition with patients finding it unhelpful being less motivated to recover and/or less compliant than those who found it helpful.

As for the few parents who found lunch-time unhelpful these were the ones who said that they knew their child wouldn't eat and thus felt they were left with an impossible task. They had predicted that they would fail and they did so not only in front of the professionals but also in the presence of other families who might have managed lunch-times better. This example suggests that the presence of the group made those parents feel more ineffective, rather than being supportive.

The role-play also generated some negative experiences with a few of the patients and the parents finding it unhelpful. In this respect it was found to be intense and arousing difficult feelings but not for any benefit. In contrast, parents and patients who found the role play helpful also attributed this to the intensity. It emerges that a defining characteristic of the exercise can have both a positive and a negative function. It is interesting however how most of those who found the role-play unhelpful talked also about their own involvement in the intervention either by being one of the "actors" and/or by observing one member of their family being one of the actors. It might therefore be the case that those families more actively involved in the intervention were more vulnerable in experiencing this intensity as unhelpful. It was their own family and illness related difficulties that were or perceived to have been more exposed.

Clinicians conducting MFT groups are aware of the role play's potential for generating a kind of "adverse reaction" especially for 'involved' individuals and their families. They are also alert in the fact that an exercise might have to be interrupted or stopped if it is escalating to a degree of being unbearable. Also, involved individuals are given the option, in advance, of terminating if and when they feel under too much pressure while after the end of the exercise families are de-briefed and given the space to de-role. All of the above are parts of good practice but, from the participants' experience it seems that there still remains a minority of individuals who find the role-play an exercise that is difficult to cope with.

Both the family lunch and the role play involved powerful and intense group and family dynamics described by Asen (2002) as a "hot-house effect" and thought to be one of the unique features of MFT day group format. This seems indeed to be the case as it emerges

from both the helpful and unhelpful experiences especially around those two interventions. Nevertheless, the associated unhelpfulness of those dynamics during these two interventions introduce a further perspective: that of those who are and/or seem to be more central and/or deviant during those instances. This is brought about by being the "odd" family who manages less well at lunch-time or whose member(s) are "picked out" to do the role play and thus be more exposed in front of the group. These individuals are more likely to experience the "hot-house" effect as unhelpful; as if the presence of the group becomes somewhat more threatening and intrusive than supportive. It might of course be that it operates the other way round whereby those individuals/families who are less able to make use of the supportive atmosphere of the group are more prone to experience intensity as unhelpful especially when they are more personally involved.

Although it would be useful for clinicians to try and minimize those stressful instances, however rarely they occur, it is difficult to have, in advance, the insight of which families or family members will experience distress. It is usually the case that this is noticed once it's occurred. A useful precaution with that respect would be to stress the universality of these difficulties in anorexia nervosa families. In other words although a family might manage lunch-time better they have certainly been in the position of the family who manages less well and/or indeed is not managing at all on that day. Similarly, the fact that one patient and/or parent is picked up as the "actor" in the role play doesn't mean that the feelings generated are within him/her self only. It is more than possible that the rest of the group would feel the same had they been actively involved in the intervention as opposed to observing it. Similarly, the function of the group as providing support and mutual understanding and not as observing and judging should be made very explicit during those interventions.

Finally, all the patients who talked about the family-tree (genogram) intervention found it unhelpful while a couple of the parents found the psycho-educational talk on the effects of starvation unhelpful.

The family tree was seen as unhelpful by those patients on the grounds that they could not see any relevance between the family representation and recovery from anorexia. They also felt that family issues had already been discussed and addressed extensively during the group. In other words, it is as if these patients would rather "leave the family out of it". This might represent an attempt by the patients to protect their family from any possible association between family life and onset/maintenance of the illness. As discussed in the previous section patients were quite aware of the feelings of guilt and blame their parents were experiencing so the perceived irrelevance of the family tree and the therapeutic context might represent these patients' attempt to establish the lack of association between family life/characteristics and onset/maintenance of the illness. Stressing that the genogram interventions is aimed at discovering family strengths rather than family dysfunction might be useful in that respect.

The unhelpfulness of the psycho-education was attributed to a perceived return to the medical model of anorexia while in a group oriented and facilitating environment; also, some of the parents said that they were already aware of the medical dangers of anorexia in which case the psycho-education was seen as distressing yet not offering any new information. In this respect it worth noting that the supportive and relatively non-medical environment of the MFT (if compared with a hospital ward for instance) might make parents and patients forget, even temporarily, the medical complications of the illness in

which instance psycho-education comes as a somewhat unwelcome reminder. It is therefore important for a balance to be maintained during MFT groups between the supportive group environment and the need not to lose sight of the medical dangers associated with anorexia.

In this section, unhelpful experiences associated with the MFT were discussed highlighting aspects of the treatment that may prove difficult for some individuals. The unhelpful experiences are not surprising given the wide range of families and the potential seriousness of anorexia. It is also not surprising that an intensive treatment such as the MFT will yield some degree of discomfort for some of the families. Nevertheless, the relative rarity of unhelpful experiences in the participants' feedback and the fact that these were associated with aspects of the treatment perceived to be helpful by most participants suggests that they represent specific difficulties rather than altogether negative aspects of the treatment. Furthermore, there is nothing, so far, which suggests that the reported unhelpful experiences compromise and/or hinder the therapeutic process; nor that they seriously diminish the treatment's acceptability to families. This feedback however, is useful for our deeper understanding of some of the families' distress during the MFT and may prove helpful for clinicians conducting future MFT groups.

8.6: CONCLUSIONS & METHODOLOGICAL CONSIDERATIONS

The main focus, in designing and conducting this qualitative study, was the exploration of helpful and unhelpful experiences associated with the MFT for adolescent anorexia nervosa from the point of view of the patients and families involved.

For this purpose, and as explained in the "qualitative methodology" section of this thesis, an open-ended approach of enquiry was adopted aiming to facilitate the participants' reflection upon these experiences while providing a space where these could be freely and openly discussed with as little interference as possible on behalf of the researcher, so as not to introduce pre-conceived ideas and perspectives about the treatment.

This open-ended method has strong advantages as well as evident limitations. First of all, this method of enquiry can only reach processes and experiences that operate on a conscious level (Lemmens et al., 2003a; 2003b) and also that are salient enough to be recalled. Nevertheless and despite the subjective nature of the data which is heavily reliant upon memory and self-report, open-ended interviewing possesses the advantage of revealing and exploring a variety of processes that may not be accessed by more objective measures such as structured questionnaires.

Revealing and exploring the participants' subjective experiences of the treatment process was of paramount importance in the present study. Data of this nature are compatible with fundamental theoretical assumptions of experiential-humanistic psychotherapy whereby the patient's continuous awareness of his/her subjective experiences constitute the primary focus of therapy (Greenberg, 1986). However, as postulated by Bloch and colleagues (Bloch et al., 1979) the possible therapeutic processes and aspects as reflected by the participants' report and discourse does not necessarily imply that these result in a positive outcome. In the present study it could be argued that it still remains unclear whether what the participants in this sample reported as being helpful actually contributed to a positive outcome, whether aspects reported as unhelpful hindered outcome, had no effect on it, or whether those perceived unhelpful experiences also had some therapeutic contribution.

The categorization of qualitative data into themes, sub-themes and main categories might have resulted in some of its richness being lost. A step taken to minimize this possibility was that a pre-defined coding method was not imposed upon the data; instead the rating method by which the transcripts were analysed emerged from the data. As in all qualitative methods, this study is open to subjectivity not only from the respondents but also from the point of view of the researcher who has a central role not only in collecting but also in interpreting the data. In order to address this issue, a second researcher rated and coded all the transcripts in order to establish between raters agreement, as required by the content analytic method employed.

Enquiring about three different levels, namely the individual, the family and the group, was done to facilitate reflection and recall of experience rather than to categorize responses under these pre-defined levels. The close observation of the data at the initial stages of the analyses also suggested that the participants' responses tended to override these three levels as they would indeed talk about processes helpful for the individual, the family and the group in an interchangeable way, irrespective of the specific level enquired about. Although Lemens et al (2003a; 2003b) in their studies analysed specific responses, under these specific levels, they also observed that therapy tended to be perceived as a whole with any experienced helpful event being repeated across the three levels. This is consistent with the approach adopted in this present study.

Another point to be made is that in this study within family agreement/disagreement as to the MFT therapeutic processed was not looked at. It was rather the case of an exploration of

therapeutic processes as perceived by the sub-groups of patients and parents. Future research of this kind could look in detail at convergence and divergence within families.

Despite the above issues this study has provided substantial insights as to how MFT is perceived by the participants that is, patients and families. Overall, MFT appears to be viewed positively as a treatment approach and is perceived as helpful as reported by these anorexia nervosa families. Irrespective of their differences in articulation, parents and patients seemed to perceive benefits associated with the support network and the specific interventions as they developed within the treatment context, while suggesting an increase in the amount of time designated for parallel adult adolescent sub-groups. Parents also reported that they benefited substantially from the MFT environment, involving their interactions with fellow-families and staff. This was despite the parents' initial worry and apprehension regarding the group setting.

MFT was also described by parents as an environment facilitating change in their parental role and within family communication, helping them to deal with and care for their child at home in a more effective and united way. Though no specific symptom improvement was perceived by the parents as occurring in their child as an immediate result of the treatment, they seemed highly satisfied with the child's acknowledgement of the illness and presence of associated problems.

In an overall sense, MFT was depicted as a containing environment facilitating interaction and exchange, generating intensification while providing mutual support. These interrelated processes were perceived to have enabled families to leave the group with more of their family resources mobilized.

As for unhelpful experiences, these were relatively few and tended to be underlined by each person's pre-existing coping strategies, demand characteristics and their role in the group at particular instances. During unhelpful instances the presence of the other families could change function and become an inhibiting rather than a facilitating factor.

Due to the overlap of treatment processes and goals between MFT and family and group therapy more research is needed to identify processes that are unique to the MFT. This could possibly be achieved by employing a similar methodology for families undergoing group and/or family therapy. Similarly, it is still unclear whether the families' perceptions of treatment experience are stable or variable over time.

The subjective nature of the data along with the fact that there are a variety of ways in which MFT is practiced for different patient populations makes generalization of the present study's findings difficult. However, the qualitative paradigm employed is primarily concerned with the exploration and description of subjective experience rather than generalization of results and/or establishment of cause-effect relationships. Nevertheless, the present study contributed important information about aspects of the MFT treatment that are perceived as helpful by participants. These are relevant with respect to engaging families in treatment in the MFT context as well as in other interventions as well as reflect some of the fundamental needs and struggles of these families which again, should be taken into account, irrespective of treatment context.

Further research is needed into this under-researched yet valuable approach addressing treatment experiences. Possible future questions may address the issues of change of

treatment experience over time (e.g. is a treatment perceived in a similar manner when patients are still in treatment as opposed to being asked in retrospect). Although it is unlikely that this strand of research will enlighten the field as to which specific mechanisms produce change it will provide important insights as to which aspects of the treatment are acceptable and make sense to families. This is of particular clinical relevance with respect to engaging families, while at a theoretical level it could throw light on the extent to which mechanisms described as important by researchers or clinicians are equally apparent to families.

PART III

QUANTITATIVE COMPONENT OF THE STUDY

CHAPTER 9

QUANTITATIVE METHODOLOGY

9.1) THE PARTICIPANTS

The patients (and their families) were 30 patients suffering from anorexia nervosa and who took part in 8 consecutive MFT groups run over a period of two years. Patients were recruited from the Adolescent Eating Disorders Services at The Maudsley and St George's Hospitals, London. Participants approached for the study were those offered and accepted to take part in the MFT program. Patients with learning disability, psychosis, or alcohol/substance dependence were excluded.

9.2) THE ASSESSMENT BATERY

a) Individual Symptom Measures (T1, T2, T3).

The patients weight height and menstrual status was routinely monitored at regular intervals by the clinician(s) responsible for his/her care. At the three assessment times however, these assessments were conducted by the investigator. The same weighting and measuring instruments were consistently used. The patients' weight for his/her height, age and sex (weight for height) will be calculated for each one of the times indicating the percentage of the patients weight with respect to normative average body weight (ABW) for height, age and sex (100% being normative level). Weight for Height is a more accurate measure for this adolescent population as it corrects for the patients age which is not the case for the more traditionally used Body Mass Index (BMI) making thus weight for height more suitable for children and adolescents as opposed to BMI which is an accurate measure for adult populations. The patients' Weight for Height will be used at its continuous level for

the statistical analyses. However, for descriptive purposes, weight for height will be used as a categorical variable for the allocation of patients' in outcome groups at each of the 3 time points. In that instance the patients' menstrual status will also be taken into account. Consistently with the Morgan Russell Classification (Morgan & Russell, 1988) commonly employed in similar studies (Dare et al., 2001; Eisler et al., 1997; 2000; Le Grange, 1989; Le Grange et al., 1992) the outcome groups will be as follows:

Good Outcome: Weight for Height above 85% of average body weight for the patients' height, age and sex; presence of menstruation and absence of binge-purge behaviour.

Intermediate Outcome: All of the above but lack of menstruation.

Poor Outcome: Weight for Height below 85% of average body weight for the patient's height, age and sex, lack of menstruation and presence of binge-purge behaviour with a frequency of once per week or more.

b) Individual Psychological Measures (T1, T2, T3).

- The Eating Disorders Inventory (EDI- 2) (Garner, 1991),was administered to the patients at the three assessment points. The original EDI-2 (Garner, 1991) is a multidimensional self-report measure designed to assess the attitudes, traits, behaviours and psychological characteristics relevant to eating disorders.

It consists of 91 items forming the following 11 dimensions: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, Maturity Fears, Asceticism, Impulse Regulation and Social Insecurity.

Answers are specified using a 6-point Likert scale in which respondents indicate whether the item is true for them always, usually, often, sometimes, rarely or never;

responses are then weighted from 0 to 3 with a score of 3 being assigned to responses farthest towards the symptomatic direction, scores 2 and 1 for the next two responses respectively and 0 for the three responses farthest in the asymptomatic direction. Subscale scores are calculated by the sum of all item scores for each particular subscale with higher scores being indicative of greater manifestation of each particular trait. In this study the EDI total score will be used[8]which can be calculated by adding up the subscale scores.

Good psychometric properties are reported for the original EDI (Bennett & Stevens, 1997; Eberenz & Gleaves, 1994) while the instrument has been extensively used in the screening of population groups or large patient samples (Fava et al., 1997; Gendall et al., 1997; Lee et al., 1997; Taylor et al., 1996),the exploration of the psychopathology of eating disorders (Fava et al., 1997; Gendall et al., 1997; Meyers, 1997; Steiberg & Shaw, 1997; Taylor et al., 1996; Van Strien, 1997) and in studies looking at the progress of patients during treatment (Clinton 1996; Marrazzi et al., 1995; Brambiulla et al., 1995). Of particular relevance regarding the selection of this instrument for the present study is its proven usefulness for the measurement of change in family based interventions (Dare et al., 2000).

- The Beck Depression Inventory (BDI- II) (Beck, Steer, & Brown, 1996) was administered to both patients and their parents/carers at the three time points. The scale was designed to standardize the assessment of depression severity in order to monitor change over time and/or to simply describe the illness. It consists of 21 item sets each with a series of 4 statements describing symptom severity along an ordinal continuum

[8] Provided a significant overlap between the subscales exists. This will be checked by calculating the relevant correlation coefficient matrix. If these aren't highly relates subscale scores will be used instead

ranging from absent/mild (a score of 0) to severe (a score of 3). The scale possess good internal consistency according to a review of 23 studies (Beck et al., 1988) which indicated a range of Cronbach's alphas of 0.76 to 0.95 in psychiatric patients, student populations and non psychiatric, non student samples.

The BDI will be used as a continuous variable for the purposes of statistical analyses but will be treated at its categorical level for descriptive purposes. The depression levels categories as defined by the instrument are as follows:

Minimal Depression:	Score 0-13
Mild Depression:	Score 14-19
Moderate Depression:	Score 20-28
Severe Depression:	Score 29-63

- The Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965) was administered to the patients at the three time points. The RSE scale is the most widely used instrument for the assessment of self-esteem (Blascovich & Tomaka, 1991), conceptualized as one's overall evaluation of his/her worthiness as a human being (Rosenberg, 1965). The scale consists of 10 items to which the participants respond on a four-point scale of agreement. Half the items convey a positive self-esteem and half convey a negative self-esteem. Items are scored from 1-4 in the direction of negative self-esteem with scores ranging from 10 to 40 and low scores being indicative of a high self-esteem. Rosenberg (1965) conceived self-esteem as a one-dimensional construct reflecting a positive or negative evaluation of the self relating to evaluations across specific areas of functioning. Although occasionally higher order structures have been reported within the RSE scale (Carmines et al., 1979) psychometric studies have generally supported

the uni-dimensionality of the instrument (Fleming & Courtney, 1984). Good internal consistency, around $\alpha = 0.8$ has been reported (Campbell, 1990). The RSE scale is used as a trait measure of self-esteem, nevertheless studies haven't directly addressed state and trait indices of the instrument. Still when compared with the temporal stability of personality dimensions self-esteem scores appear to fluctuate more over time, thus suggesting that self-esteem is a rather variable and dynamic trait than a stable individual characteristic (Johnson, 1998).

The measure enables the investigator to discriminate between a positive and negative self-esteem as well as changes in self-esteem across time. However, Rosenberg (1965) provided no cut-off points to distinguish 'high' or 'low' self-esteem.

The RSE scale's ability to predict outcome in an eating disorder sample was demonstrated by Fairburn et al., (1987). Furtehrmore, when the RSE scale was compared with the Coopersmith Self-Esteem Inventory (Coopersmith, 1967) upon 117 inpatient eating disorders sufferers it was indicated that the RSE scale possessed sounder construct and convergent validity in this sample than the SEI with the authors recommending the use of the RSE scale in eating disordered patients (Griffiths et al., 1999).

c) Family Assessment (T1,T2,T3).

- The family meeting and Expressed Emotion (EE) ratings: EE taps the feelings that a relative expresses in relation to a symptomatic member of the family (Vaughn & Leff, 1976b). Five principle scales comprise this measurement: criticism (CC), hostility (Hos), emotional over involvement (EOI), warmth (W) and positive remarks (PR). Both CC and PR ratings are frequency counts. The former refers to total number of critical comments towards the relative and the later involves statements showing praise, appreciation or

approval of the behaviour and/or personality of the relative. Hostility is defined as either a generalized criticism of the individual, a rejection of the patient as a person or a combination of both. Emotional over involvement can be detected either from the respondent's behaviour during the interview or reported behaviour outside the interview. The type of behaviour that gives rise to a high score here is any combination of the following: unusually self-sacrificing behaviour, exaggerated emotional responses and inappropriate over protection in response to the patient's age. Warmth does not refer to a general quality in the respondent's personality, but to the way in which the relatives respond to the patient. This is expressed in the amount of enthusiasm, empathy, sympathy and the like that the respondent shows for the patient (Leff & Vaughn, 1985; Vaughn & Leff, 1976a; Vaughn et al., 1976b).

Hostility, Emotional Over-involvement and Warmth are rated on the following global scales:

HOSTILITY

0 No Hostility **1** Generalisation **2** Rejection **3**Both Gen. & Rej.

EOI

0 No EOI **1** Very Little **2**-Some **3**Moderately High **4** High **5** Marked

WARMTH

0 No Warmth /**1** Very Little /**2** Some / **3** Moderate / **4** Moderately High/**5**Marked

Expressed Emotion was rated through the use of the Standardised Clinical Family Interview (SCFI) (Kinston & Loader, 1984; 1986). The SCFI is designed for use with a range of families both labeled and non-labeled addressing what the authors referred to as system properties exploring areas of family life including the way the family sees itself, degree of togetherness, who does what with whom, similarities and differences

among family members as well as roles and responsibilities and areas of conflicts and disagreements. In the present study and consistently with previous studies conducted by our unit a further domain was explored involving the families' experience around the patient's eating disorder.

The SCFI has been validated for the rating of EE, within a whole family setting, when compared to the customarily used Camberwell Family Interview (Brown & Rutter, 1966; Vaughn et al., 1976a) designed for use with a single relative (Hodes, et al., 1999) . The SCFI has also been used extensively in the rating of EE in families containing an eating disordered relative (e.g. Dare et al., 1994; Dare et al., 2000; Eisler et al., 2000; Le Grange, 1989; Le Grange et al., 1992).

- <u>The Self-Report Family Inventory (SFI)- Health and Competence Scale. (Beavers, Hampson, & Hulgus, 1985)</u>

This is the largest and principal subscale of the SFI comprising of 19 items which are statements regarding family life. Participants are asked to rate the extent to which each statement fits their family using the 5-point Likert Scale below:

1 ***"Yes: Fits our family very well"***
2
3 ***"Some: Fits our family some"***
4
5 ***"No: Does not fit our family"***

The issues addressed include happiness problem-solving and negotiation, optimism, individuality, family love, parental coalitions and blaming versus responsibility patterns.

The SFI possess good psychometric properties (Hampson & Beavers, 1996b; Hampson & Beavers, 1996a) while the primary Health and Competence Scale is found to correlate highly with the General Functioning Scale of the Family Assessment Device (Miller et al., 1985) which is another self- report scale measuring a conceptually similar dimension. Although no strict cut-off points are provided for the Health and Competence SFI Scale, the authors suggest that a raw score of 57 or above suggests a less competent family. The SFI's Health and Competence scores would be used at their continuous level.

d) Satisfaction with treatment

- The Client Satisfaction Questionnaire (CSQ) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979)

This is an 8-item, 4-point Likert type questionnaire addressing general client/patient satisfaction with health care services with a high total score being indicative of high client/patient satisfaction. The authors of the questionnaire have reported good psychometric properties (Attkisson & Zwick, 1983) while it is a quick and easy measure to administer that can be easily incorporated into clinical practice. Patients and parents completed the questionnaire at some point between two and four weeks following the MFT.

9.3) STATISTICAL PROCEDURES [9]

a) Change over time in patient outcome.

Statistical analyses in that instance will address the first hypothesis of this study examining whether there is improvement in patients' biological symptoms, psychological functioning and eating disorders cognitions at three and six months follow up. For this purpose a series

[9] All the statistical procedures to be performed involve parametric tests. Therefore, all dependent variables will be tested for normal distribution, which, if not established, non-parametric alternative tests will be considered.

of Regressions with subject clusters and robust standard errors will be performed. This statistical test was decided upon due to its ability to deal with the repeated measures nature of the data. The Independent Variable will be Time of Assessment while the dependent variables of the analyses will be:

- Weight for Height
- Eating Disorders Inventory (EDI)
- Beck Depression Inventory (BDI)
- Rosenberg Self-Esteem Scale (RSE)

An overall significant effect of time will be tested for, while regression coefficients will illustrate the amount of change taking place at the specific time points assessed:

- Baseline (T1) to 6 month follow-up (T3)
- Baseline (T1) to 3 month follow-up (T2)
- 3 month follow-up (T2) to 6 month follow-up (T3)

***b) Change over time in Family Variables*.**

Again, due to the repeated measures nature of the family data statistical procedures similar to the above will be employed to address the second hypothesis of the study enquiring about change in family factors at three and six months follow-ups. Similar to the procedure on patients' outcome, the Independent Variable across analyses will be Time of Assessment with Dependent Variables as follows:

- Maternal and Paternal Beck Depression Inventory (BDI)
- Maternal, Paternal and Patient SFI (SFI)
- Maternal and Paternal Expressed Emotion (EE) towards the patient.

- Maternal and Paternal EE towards each other.

For the first two Dependent Variables (BDI & SFI) regression analyses with subject clusters and robust standard errors will be used while for EE scores ordinal logistic regressions with subject clusters and robust standard errors will be used taking into account the ordinal nature of EE data.

c)Examining the relationship between family variables and patient outcome

The third and fourth hypotheses will be addressed testing whether baseline family factors as well as change in family factors are predictive of the patients' symptomatic outcome (i.e. weight for height). Statistical procedures in that instance will involve a two stage process:

First Stage: A series of regression analyses will be performed for each of the family variables (maternal & paternal BDI and EE scores and maternal, paternal and patient SFI scores) with baseline and change scores[10] as independent variables and weight for height as the dependent variable.

Second Stage: The variables found to be significantly associated with outcome, if any, will then be entered into a combined multiple regression model as the dependent variables and weight for height as outcome. This is provided that the predictor variables are not highly correlated between them in which case variables will be reduced so as to produce the least overlap between the predictors.

[10] A change score will be calculated for each of the variables.

CHAPTER 10

QUANTITATIVE RESULTS

10.1) THE PATIENTS & THE FAMILIES AT ENTRY TO THE STUDY

Thirty patients and their families who participated in 8 MFT groups took part in the study 27 of whom were female and 3 were male. The majority of the patients (n=27) had a diagnosis of Anorexia Nervosa (25 restricting type; 2 binge-purge type) and 3 were diagnosed as having Eating Disorder Not Otherwise Specified (EDNOS). Three of the patients were in-patients at the time of entry to the study while 6 of the patients had been inpatients at some point in the past but the majority of the patients (n=24) had not had specialist inpatient treatment for their eating disorder. At entry to the study none of the female patients (n=27) were menstruating regularly with most of them (n=19) being amenorrhoeic or menstruating irregularly (n=3) and five being pre-menarchal. Table 7 below shows the details of the patients' age, length of symptoms and weight for height at entry to the study.

Table 7. Patients' characteristics at entry to the study

	Minimum	**Maximum**	**Mean**	**S.D**
Age	11.5	18.8	15.4	1.8
Weight for Height	62.07	88.90	75.96	6.43
Length of Symptoms (months)	3	36	11.7	10.2

Of the 30 families the majority (n=22) were intact at entry to the study, three were divorced, two were reconstituted while there was one widowed, one single parent and one adoptive family. Half of the families (n=15) were classified as social class I & II and the rest (n=15) were within social class III & IV. Overall, thirty patients, twenty nine mothers and twenty two fathers accepted to participate in the study. Two of the families dropped out from both the treatment and the study (one family was rated as high EE and the other as low- EE at the T1 interview). Of those, one patient accepted to provide the researcher with feedback on her weight, height and menstrual status at 3 and 6 month follow-ups while the other patient declined this option.

10.2) PATIENTS AT BASELINE AND 3 & 6 MONTHS FOLLOW-UP

At time of entry into the study almost all the patients were in the poor functioning group and none was in the good functioning group[11]. After three months of treatment (T2) nearly half were categorized as having a good or intermediate outcome and by 6 months (T3) this number had risen to over 60%. Nevertheless just over one third (n=11) of the original sample was still in the poor outcome group by the 6 months follow up.

Results on the patients' outcome categories across the three time points are presented in table 8 below while mean statistics for the patients' weight for height (W4H) are shown in table 9.

[11] Morgan- Russell Classification Schedule (Morgan & Rissell, 1988)

Table 8. Patient outcome categories				
Patient @ Time	**Poor**	**Intermediate**	**Good**	**N**
Patient T1	90% (n=27)	10% (n=3)	0% (n=0)	30
Patient T2	51.8% (n=15)	41.5% (n=12)	6.7% (n=2)	29
Patient T3	37.9% (n=11)	41.4% (n=12)	20.7% (n=6)	29

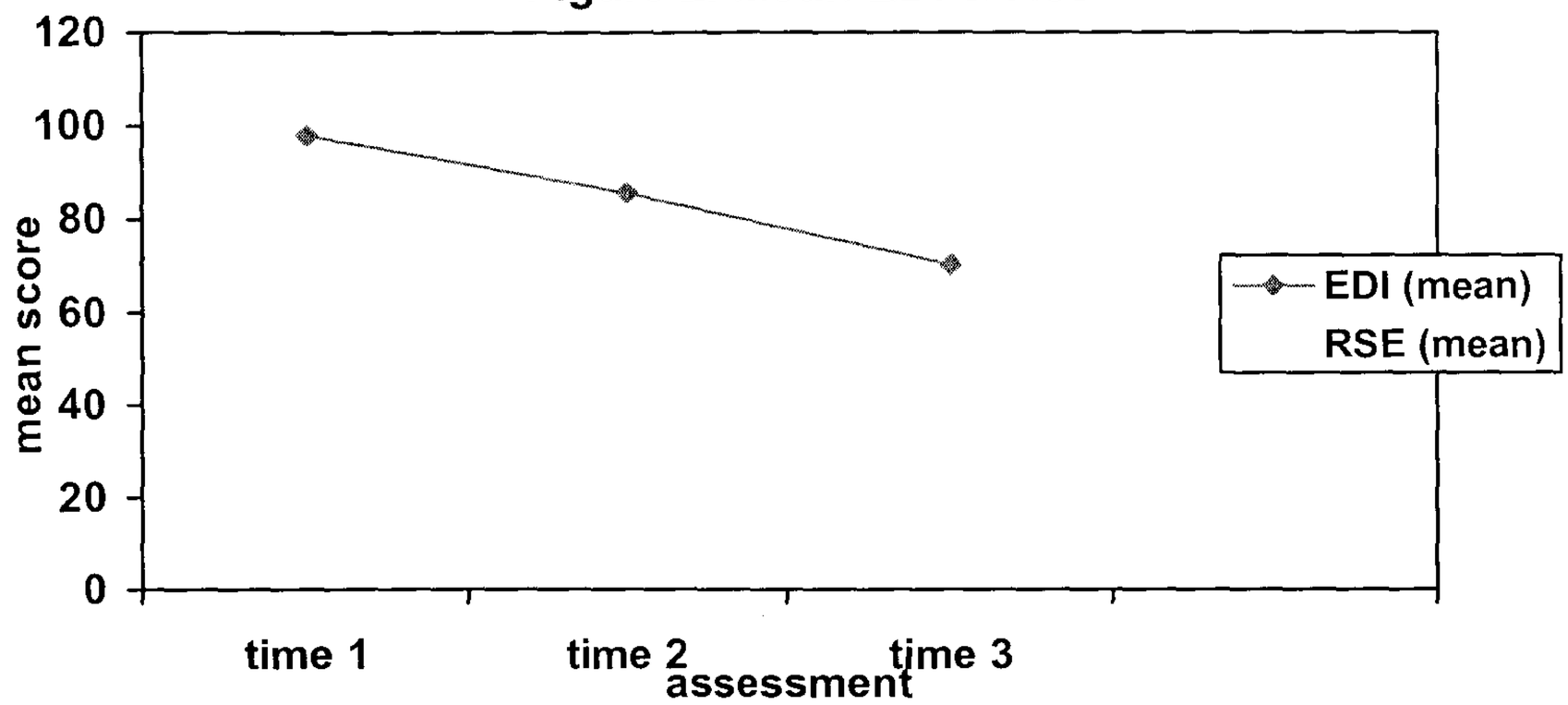
Table 9. Patient W4H			
Time	**Mean**	**SD**	**N**
Time 1 Baseline	75.9% (62%-88.9%)	6.4 %	30
Time 2 3 months FU	83 % (70.2%-97.6%)	7.7%	29
Time 3 6 months FU	86 % (69.7%-99.8%)	8.7 %	29

As for the patients' BDI scores (illustrated in table 10 below) approximately two thirds of them were moderately/severely depressed at entry to the study while by T2 half the sample were moderately/severely depressed and the other half were mildly/minimally depressed. By the 6 month follow-up almost two thirds of the patients were minimally depressed while one third remained severely/moderately depressed by the last follow-up (T3).

Table 10. Patient BDI					
Patient @ time	**Minimal Depression**	**Mild Depression**	**Moderate Depression**	**Severe Depression**	**N**
Patient T1	17.3% (n=5)	13.8% (n=4)	31% (n=9)	37.9%(n=11)	29
Patient T2	41.6%(n=10)	8.3% (n=2)	20.8%(n=5)	29.2%(n=7)	24
Patient T3	56.6%(n=17)	0% (n=0)	13.4%(n=4)	20% (n=6)	27

There were similar improvements over time in eating attitudes (as measured by the EDI) and self-esteem (RSE scores) as seen in figure 2 below.

Figure 2. Mean EDI & RSE



A series of regressions with subject clusters and robust standard errors were performed for each one of the patient outcome variables (weight for height, EDI, BDI and RSE). At each analysis, **Time** was entered as the independent variable testing for an overall significant effect of time as well as change in the outcome (dependent variable) from T1 to T2 and T3. Further post-hoc tests were performed to also identify the amount of change taking place between T2 and T3.

A highly significant effect of time was found for all the patient outcome variables with this, being in all cases, in the expected direction (table 11). Most of the weight gain, as indicated by the regression coefficients took place during the first 3 months of therapy while a substantial weight gain continued for the subsequent 3 months. In terms of the patients' depression (BDI), eating disorders psychopathology (EDI) and low self-esteem (RSE) the relevant reductions and thus patient improvement across these variables observable at the 6 month follow-up was almost equally split in the two trimesters assessed.

Table 11. Patient change at 3 & 6 months						
Patient Measure	**Coefficient T1 to T2**	**Coefficient T2 to T3**	**Coefficient T1 to T3**	**Degrees of Freedom**	**F test**	**Significance**
W4H	7.037	3.049656	10.08666	2, 29	17.54	p= 0.0000
EDI	-12.41667	-15.3141	-27.73077	2, 28	5.24	p= 0.0116
BDI	-5.038793	-5.782407	-10.8212	2, 28	12.16	p= 0.0002
RSE	-3.053793	-3.36	-6.413793	2, 28	9.96	p= 0.0005

10.3) FAMILIES AT BASELINE AND 3 & 6 MONTHS

a) BDI & SFI

As indicated in table 12 below, none of the parents had BDI scores in the severe depression range. However, just over half the mothers (n= 16) were mildly to moderately depressed at baseline which had reduced to about 30% (n= 8) by the last follow-up.

Table 12. Parental BDI					
Relative @ Time	**Minimal Depression**	**Mild Depression**	**Moderate Depression**	**Severe Depression**	**N**
Mother T1	44.6% (n=13)	34.3%(n=10)	20.4%(n=6)	0% (n=0)	29
Mother T2	56% (n=14)	16% (n=4)	28% (n=7)	0% (n=0)	25
Mother T3	71.3% (n=20)	14.4%(n=4)	14.4% (n=4)	0% (n=0)	28
Father T1	80.9% (n=21)	19.1% (n=5)	0% (n=0)	0% (n=0)	26
Father T2	91% (n=20)	2% (n=2)	0% (n=0)	0% (n=0)	22
Father T3	87.5% (n=21)	8.3% (n=2)	4.2% (n=1)	0% (n=0)	24

A series of regression analyses with subject clusters and robust standard errors where performed to test for change over time in parents' BDI and parents' and patients' SFI. In each analysis **BDI** and/or **SFI** of each family member was used as the Dependent Variable

and **Time of Assessment** as the Independent Variable examining the overall effect of time upon the Dependent Variable. These results are illustrated in table 13 below.

Table 13. Change in parental BDI & family SFI						
Measure	**Coefficient T1 to T2**	**Coefficient T2 to T3**	**Coefficient T1 to T3**	**Degrees of Freedom**	**F test**	**Significance**
BDI-Mother	-.91	-3.38	-4.29	2, 28	4.63	p= 0.0183
BDI-Father	-3.13	.65	-2.48	2, 25	4.83	p= 0.0169
SFI - Mother	1.17	.77	1.95	2, 28	0.74	p= 0.4859
SFI - Father	-1.05	1.46	.41	2, 25	0.56	p= 0.56
SFI - Patient	2.71	-1.12	1.59	2, 28	0.94	p= 0.4009

A significant effect of time was found, similarly to patient results, on both maternal and paternal BDI scores with both of them reducing over time. For mothers, a slight reduction on their depression levels occurred during the first 3 months into treatment while most of the reduction occurred in the subsequent 3 months. As for the fathers, most of the reduction in depression took place between T1 and T2 while a small increase in BDI levels was found between T2 and T3 reducing thus slightly the drop of BDI levels observed between T1 and T3.

In terms of the families SFI levels, no significant effect of time was found for any of the family members. In fact, very little change seemed to have taken place across time for the families SFI levels and this was not always in the expected direction. Moreover, as shown in table 14 below, mean SFI scores for all family members fell within mid- range levels of family competence, being indicative of adequate family functioning.

Table 14. Mean family members' SFI			
Family member @ Time	**Mean SFI**	**SD in SFI**	**N**
T1 Mother	41.62 (24-61)	9.937	29
T2 Mother	42.80 (24-58)	10.49	25
T3 Mother	43.57(25-61)	9.335	28
T1 Father	39.77 (19-59)	10.12	25
T2 Father	38.91(20-59)	10.19	22
T3 Father	40.37(19-57)	10.56	24
T1 Patient	46.03(24-78)	12.91	29
T2 Patient	48.75(28-78)	12.76	24
T3 Patient	47.63(29-75)	11.09	27

***b) EE towards the patient*.**

Descriptive statistics on maternal and paternal EE towards the patient across time are presented below (tables 15 and 16). Small reductions in critical comments (CC), hostility and emotional overi-nvolvement (EOI) as well as increases in Warmth and Positive Remarks can be observed in both maternal and paternal mean EE levels. Both mothers' and fathers' levels of EE tend to be relatively low for all scales and across all assessment times.

Table 15. Mean maternal EE			
CC	**Mean**	**SD**	**N**
Time 1	1.45 (0-7)	1.88	**29**
Time 2	1.40 (0-7)	2.12	**25**
Time 3	.78 (0-5)	1.36	**27**
Positive Remarks	**Mean**	**SD**	**N**
Time 1	.93 (0-5)	1.10	29
Time 2	1.48 (0-5)	1.41	25
Time 3	1.37 (0-6)	1.47	27
EOI	**Mean**	**SD**	**N**
Time 1	1.93 (0-4)	1.30	29
Time 2	1.80 (0-5)	1.44	25
Time 3	1.59 (0-4)	1.15	27
Warmth	**Mean**	**SD**	**N**
Time 1	2.03 (0-4)	1.14	29
Time 2	2.56 (0-5)	1.29	25
Time 3	2.44 (0-4)	1.18	27
Hostility	**Mean**	**SD**	**N**
Time 1	.59 (0-3)	1.05	26
Time 2	.68 (0-3)	1.21	25
Time 3	.22 (0-3)	.80	27

Table 16. Mean paternal EE			
CC	**Mean**	**SD**	**N**
Time 1	1.09 (0-4)	1.50	22
Time 2	1.33 (0-5)	1.45	18
Time 3	.60 (0-4)	1.09	20
Positive Remarks	**Mean**	**SD**	**N**
Time 1	.64 (0-3)	.848	22
Time 2	.94 (0-3)	.938	18
Time 3	1.10 (0-3)	1.07	20
EOI	**Mean**	**SD**	**N**
Time 1	1.20 (0-4)	.95	22
Time 2	1.50 (0-4)	.92	18
Time 3	1.10 (0-4)	1.07	20
Warmth	**Mean**	**SD**	**N**
Time 1	1.98 (0-4)	1.13	22
Time 2	2.00 (1-4)	1.13	18
Time 3	2.26 (0-4)	1.28	20
Hostility	**Mean**	**SD**	**N**
Time 1	.38 (0-3)	.86	22
Time 2	.50 (0-3)	1.04	18
Time 3	.20 (0-3)	.69	20

In order to empirically test for change over time in parents' EE levels a series of similar statistical procedures were followed only this time Ordinal Logistic Regressions with subject clusters and robust standard errors were performed. This was done in order to deal with the ordinal nature of the EE data. Again, each **EE score** was entered as the Dependent Variable and **Time** as the Independent Variable.

In terms of the maternal EE scores, most results (table 17 below) were in the expected direction with decreases in Critical Comments, Emotional Over-Involvement and Hostility and increases of Positive Remarks and Warmth. Nevertheless, statistical significance was not reached for changes on any of the scales.

Table 17. Changes in Maternal EE (ordinal logistic regressions)

EE Scale	Coefficient T1 to T2	Coefficient T2 to T3	Coefficient T1 to T3	Chi2 (2) test	Significance
CC – mother	-.03	-.53	-.56	2.28	p= 0.3196
EOI-mother	-.29	-.14	-.43	1.13	p= 0.5681
Hostility	-.03	-1.58	-1.61	5.33	p= 0.0698
P.R	.75	-.21	.53	4.11	p= 0.1283
Warmth	.75	-.14	.61	4.35	p= 0.1137

Similar to maternal EE scores the results (table 18) have indicated that paternal EE levels towards their ill child also changed in the expected direction with overall decreases over time for CC, EOI and Hostility and relative increases in Warmth and PR. In this instance the only variable found to change at a level of statistical significance over time is CC. Both CC and EOI appear to increase slightly in the first instance; that is, within the first 3 months of therapy but then drop quite substantially in the subsequent three months. The rest

of the changes in paternal EE scores, as illustrated by the regression coefficients, are very small and thus, despite being in the expected direction, do not reach statistical significance.

Table 18. Changes in paternal EE (ordinal logistic regressions)					
EE Scale	**Coefficient T1 to T2**	**Coefficient T2 to T3**	**Coefficient T1 to T3**	**Chi2 (2) test**	**Significance**
CC –father	.59	-1.11	-.52	9.20	p= 0.0101
EOI- father	.85	-.93	-.07	4.83	p= 0.0894
Hostility	-.15	-.99	-1.14	3.50	p= 0.1738
P.R	.66	.22	.89	2.46	p= 0.2918
Warmth	.36	.45	.82	2.84	p= 0.2417

C)EE between the parents

Descriptive statistics on the levels of EE between the parents across baseline and three and six month follow-ups are illustrated in tables 19 and 20 below.

As it appears by both mean CC and PR levels most parents tended to be relatively un-expressive towards each other in the two indexes with this being the case across time and with relatively few of the parents making either Critical Comments and/or Positive Remarks towards their spouse. Similarly, levels of Hostility and Warmth between spouses are low across all three assessment points.

Table 19. Mean EE from mother to father			
Critical Comments	**Mean**	**S.D**	**N**
Time 1	.67(0-5)	1.27	28
Time 2	.75(0-5)	1.45	24
Time 3	.65(0-5)	1.35	26
Positive Remarks	**Mean**	**S.D**	**N**
Time 1	.21(0-2)	.49	28
Time 2	.45(0-2)	.58	24
Time 3	.57(0-3)	.80	26
Warmth	**Mean**	**S.D**	**N**
Time 1	.57(0-4)	.9595	28
Time 2	1.33(0-4)	1.4939	24
Time 3	1.30(0-4)	1.1922	26
Hostility	**Mean**	**S.D**	**N**
Time 1	.21(0-3)	.7868	28
Time 2	.37(0-3)	.9237	24
Time 3	.34(0-3)	.8918	26

Table 20. Mean EE from father to mother			
Critical Comments	**Mean**	**S.D**	**N**
Time 1	.50(0-5)	1.18	22
Time 2	.83(0-6)	1.82	18
Time 3	.73(0-5)	1.40	19
Positive Remarks	**Mean**	**S.D**	**N**
Time 1	.31(0-3)	.83	22
Time 2	.27(0-1)	.46	18
Time 3	.63(0-3)	.95	19
Warmth	**Mean**	**S.D**	**N**
Time 1	.86(0-4)	.99	22
Time 2	1.38(0-4)	1.46	18
Time 3	1.52(0-4)	1.46	19
Hostility	**Mean**	**S.D**	**N**
Time 1	.13(0-3)	.63	22
Time 2	.38 (0-3)	.97	18
Time 3	.36(0-3)	.95	19

Ordinal Logistic Regressions with Robust Standard Errors were also performed to examine change over time in EE levels between the parents with **EE scores** being the Dependent Variable and **Time** the Independent Variable.

As indicated in the results presented in table 21 below, the only significant effect of time in the between parents EE was found in Warmth exhibited by mothers towards fathers which showed a substantial increase in the first 3 months of therapy followed by a slight, further increase occurring between 3 and 6 months.

Table 21. Changes in EE between the parents (ordinal logistic regression)					
EE Scale	**Coefficient T1 to T2**	**Coefficient T2 to T3**	**Coefficient T1 to T3**	**Chi2 (2) test**	**Significance**
CC mother to father	-.07	-.12	-.20	0.41	p= 0.8143
CC father to mother	.09	.32	.42	0.91	p= 0.6351
Hostility mother to father	.90	-.09	.80	3.88	p= 0.1436
Hostility father to mother	1.40	-.06	1.34	2.67	p= 0.2637
P.R mother to father	1.1	.15	1.26	5.47	p= 0.0648
P.R father to mother	.62	.61	1.24	3.22	p= 0.2000
Warmth mother to father	1.11	.14	1.26	10.35	p= 0.0056
Warmth father to mother	.53	.20	.74	3.00	p= 0.2235

10.4) ASSOCIATION BETWEEN BASELINE/CHANGE SCORES IN FAMILY VARIABLES AND PATIENT OUTCOME

Step 1: Unadjusted effect: selecting dependent variables for the definitive analyses

A series of regression analyses with subject clusters and robust standard errors was performed for each of the family variables (maternal and paternal BDI and EE towards the patient and the spouse and maternal, paternal and patient SFI scores) with baseline and change scores as the Independent Variable(s) and weight for height as the Dependent Variables. Table 22 illustrates details on the variables found to be significantly and/or show a trend towards being significantly associated with patient weight for height.

Table 22. Family variables as predictors of patient outcome (unadjusted effect)

Variable	**Coefficient**	**t**	**p**
Mother BDI **change**	-.52	(2,28) –2.48	0.019
Father BDI **change**	-.48	(2,25) -.489	0.064
Father CC **change**	-2.80	(2,21) –4.13	0.000
Father Warmth **change**	2.28	(2,21) 1.98	0.061
Father EOI **baseline**	2.78	(2,21) 2.27	0.034
Father Warmth **baseline**	3.47	(2,21) 2.18	0.040

In terms of parental BDI, maternal change scores were found to be significantly associated with patient outcome while paternal change scores show a trend towards significance. In both parents, reduction in their depression levels is associated with a higher patient weight for height. As for the parents' EE scores towards the patient paternal CC, Warmth and EOI levels are significantly related to patient outcome. More specifically, a reduction in paternal CC is associated with a better outcome (higher weight for height) and paternal baseline scores in Warmth and EOI are also associated with outcome with higher baseline scores in these subscales being associated with a better outcome. None of the maternal baseline

and/or change scores in the EE levels towards the patient was found to be a significantly related to the patients' weight and the same was the case for baseline and/or change scores in the SFI instrument across all family members. Also EE between the parents was not found to be related to patients' Weight for Height.

Step 2: Adjusted effect of dependent variables- definitive analyses

Baseline and change scores of variables found, from the above unadjusted analyses, to be significantly associated with outcome were entered, as independent variables, in a combined multiple regression model. However, the variables of paternal Warmth and EOI were highly correlated (r=. 615; p< .01) and thus the variable retained was paternal EOI due to its higher significance as illustrated in table 22 above. Therefore, in this final analysis the dependent variables were:

- Baseline and Change Scores in Maternal BDI
- Baseline and Change Scores in Paternal CC
- Baseline and Change Scores in Paternal EOI

According to the results of the multiple regression model (table 23) the only variables found to significantly predict the patients' weight for height after having adjusted for the effect of the variables found to be significantly associated with outcome in the adjusted models were change of paternal CC and EOI. A reduction of CC and an increase in EOI were associated with a better outcome in terms of the patients' weight for height.

Table 23. Definitive analyses of family variables as predictors of patient outcome			
Variable	**Coefficient**	**t**	**p**
Mother BDI **Baseline**	.03	0.15	0.880
Mother BDI **Change**	-.30	-1.27	0.218
Father CC **Baseline**	-1.14	-0.84	0.413
Father CC **Change**	-3.54	-2.62	0.016
Father EOI **Baseline**	2.95	1.53	0.143
Father EOI **Change**	3.49	2.21	0.039

10.5) PATIENTS' & PARENTS' SATISFACCTION WITH TREATMENT.

Overall, the results have indicated high levels in the Client Satisfaction Questionnaire (CSQ) across all family members as is summarized in table 24 with maternal and paternal ratings being very similar and patient ratings slightly lower yet still indicating high client satisfaction.

Table 24. Mean CSQ ratings			
Family member	**Mean**	**SD**	**N**
Patient CSQ	24.6 (11-32)	5.3	29
Mother CSQ	27.9 (21-32)	3.4	29
Father CSQ	27.5 (20-32)	3.7	25

A paired samples t-test was conducted to examine differences in CSQ between family members. No significant differences were found between mothers and fathers ($t = .7$; $p>.05$) while patients' CSQ were significantly lower than those of mothers ($t = -4.4$; $p< .01$) and/or fathers ($t = -4.1$; $p< .01$)

CHAPTER 11

DISCUSSION OF QUANTITATIVE RESULTS

11.1) DO PATIENTS IMPROVE DURING MFT?

In terms of the patient outcome data, the results have indicated a significant improvement across all levels assessed over time. More specifically, at entry to the study and beginning of the treatment the patients were low in weight as indicated by their weight for height. Their eating attitudes and cognitions as assessed by the EDI were also negative. Most of the patients were depressed and had low self esteem. By the six month follow-up, most patients had reached normative levels of weight for height and mood while their self-esteem and EDI had clearly improved. However, despite having reached normal levels of weight for their height, age and sex, a number of patients fell within the intermediate outcome group due to lack of menstruation. This is not surprising as few patients would have been at a healthy weight for long enough at this stage for their periods to have restarted and classifying them as having an intermediate outcome might not adequately reflect the extent of their improvement.

About one third of the patients remained unwell at six months, their weight and depression levels were still within anorexic and clinical depression ranges, while they maintained a high EDI and RSE scores which indicated high eating disorders psychopathology and low self-esteem.

Overall the results of this study, are quite encouraging with respect to the usefulness of the MFT treatment for this patient population. However, there are various issues that need to be

taken into account before drawing conclusions about the MFT's effectiveness for anorexia nervosa and these will be discussed below.

Possibly, the most obvious such issue is the lack of comparison with a control group. This is especially the case given that the ratio of two thirds of the patients getting better with one third remaining poorly, found in this study, is very similar to general outcomes reported in anorexic children and adolescents that are achieved irrespective of treatment (Neiderman, 2000). It is thus impossible to know whether the positive patient outcome(s) found in this study were due to the specific effects of the MFT treatment.

Relevant to this issue is also the fact that, as noted in the introductory section of this thesis, there is considerable evidence for the benefits associated with involving the family in the patients' treatment (Crisp et al., 1991; Eisler et al., 1997; 2000; Herscovici & Bay, 1996; Le Grange, 1989; Le Grange et al., 1992b; Russell et al.,1987) in adolescent anorexia nervosa.

With this respect, it should be noted that the MFT employed in this study has a strong family therapy component and various treatment objectives similar to the Maudsley model of family therapy found to be effective with anorexic patients (Eisler et al., 1997; 2000; Le Grange et al., 1992b) as well as with other family therapy models also shown to be effective (Robin et al.,1995). Common objectives include the aim to engage parents in their child's treatment and empower them to exercise control over their child's eating while issues of individuation and separation from the family as well as inter-generational conflicts, expectations and boundaries are also addressed. Also, MFT meetings were

complemented, where needed, by individual family therapy sessions. Despite these similarities though, the MFT possessed the novel characteristic of its intensive nature as well as the formation of a group bringing families with similar situations and experiences together. This study, however, does not tell us whether these characteristics of the MFT, bring any clinical benefits over and above those associated with individual family therapy.

Comparing the results of the present study regarding weight gain with those reported by the Maudsley group (Eisler et al., 2000) in their most recent study comparing two family interventions for adolescent anorexia nervosa (conjoint Vs separated family therapy) an interesting finding emerges: The mean weight gain found in the present study to have occurred by the six month follow-up (10.1% of Average Body Weight-ABW) is very similar to that reported after twelve months of conjoint and separated family therapy (10.2% ABW & 15% ABW accordingly) possibly indicating that in the context of the MFT weight gain occurs faster with a substantial amount of weight gain having actually occurred by the first three months of treatment (7.1% ABW). Therefore, the substantial improvements especially in the patients' weight that took place relatively early, as compared to previous results, might point to at least some contribution of the specific treatment in the positive outcome achieved by most patients.

It also worth noting that the study population was drawn from a tertiary referral clinic with most of the referrals coming from G.Ps and/or consultant psychiatrists who felt that these patients needed specialist treatment. Some of the referrals actually presented to the service with a request for inpatient admission either because of the emaciated state of the patient or

due to his/her very rapid and escalating weight loss naturally increasing the anxiety of professionals and parents alike.

In this respect it is quite encouraging that most patients managed to improve outside of hospital with only a couple requiring inpatient admissions. Moreover, most parents managed to engage with outpatient work despite their fear and anxiety about their child's health and their, so often encountered, sense of their own ineffectiveness to help the child and associated belief that hospitals are better than parents in helping patients recover from anorexia.

Another problem in drawing conclusions about the effectiveness of MFT in the treatment of anorexia nervosa is that the patient sample in the present study mainly consisted of young patients with a relatively short illness duration. It is therefore unclear whether similar clinical benefits would be achieved in patients thought to have an unfavourable prognosis due to the late onset and chronic/longer duration of their illness (e.g. Theander, 1970; Morgan & Russell, 1975; Hsu et al., 1979).

Similarly, as noted by various authors (e.g. Morgan & Russell, 1975; Hsu et al., 1979), anorexia nervosa is an illness which can have a prolonged course. As such and if outcome is to be ascertained, patients should be followed-up for at least four/five years. Therefore, the six-month follow-up imposed in the present study by the time limitations of a PhD thesis restricts drawing anything but tentative conclusions.

This has implications for both the patients who remained unwell as well as for the majority of patients who improved significantly by the six months. For the former group of patients, the lack of substantial improvement should not necessarily be seen as their definite outcome as there was a possibility of them catching-up with their improved fellow-patients later on in time and with more therapeutic input. As for the latter group of improved patients, the six month follow-up has the limitation of it being too soon a period to detect possible relapses.

A longer follow-up period would therefore have been useful both in terms of allowing more time for patients who remained unchanged to achieve possible improvements as well as evaluating whether patients who got better would eventually relapse. In other words, the results of this study should be seen as indications of the patients' short term outcome, while inferences about maintenance of clinical benefits over time and/or long-term outcome cannot be made.

Sample size is another point to be considered which, although having been relatively adequate for detecting changes in the outcome measures used, it still remains relatively small for the generalisation of findings to the entirety of anorexia nervosa sufferers.

Nevertheless, and despite the relatively small sample size, this study has the advantage of a very low attrition rate being under 10% with this also extending and perhaps being symptomatic of the very small rate of drop-outs from treatment. In fact those few families who dropped out of the research were those who had already made the decision to discontinue treatment.

Another issue to be discussed involved the effect of a selection bias upon the results. This was possibly introduced as eligibility for the study was on the basis of having accepted the MFT option instead of it being on an intention to treat basis. No data is available for the families who declined the treatment and it is therefore difficult to know whether they were systematically different, in terms of patient and family characteristics from those who accepted it. Similarly, as numbers of those who declined the treatment were not available it is difficult to know how easy and/or difficult it was to engage families in the MFT in the first place.

As noted previously, a substantial improvement took place across all patient variables assessed. It is difficult however to know whether improvement in weight lead to the improvements in psychological and eating disorders psychopathology variables or Vice Versa; that is, because the patients felt less depressed, had a higher self-esteem and their eating disordered cognitions improved they were more able to eat more and restore their weight. The fact that most weight gain took place by three months might possibly show that weight gain preceded the other improvements. However, such a priming effect was not tested in the study and therefore one should rather conclude that improvements in weight and psychological and eating disorders variables tended to occur together, possibly in an inter-related manner (e.g. weight gain improves depression levels which in turns make eating more possible).

Lastly, a broad definition of outcome was intended and assessed in the present study.

However, there are other areas of the young person's life which in our experience as well as according to empirical findings are compromised by anorexia nervosa. These include social adjustment and quality of life in terms of studies, schooling, leisure activities, peer relations and social isolation (Bohle et al., 1991; Treasure et al., 1992) as well as sexual adjustment in terms of interest in and satisfaction with intimate relationships as well as positive and/or negative regard of own body and associated feminine appearance (Leon et al., 1985; Morgan & Russell., 1975).

No measures across these levels of functioning were taken in this study, mainly in order not to overload the rather lengthy assessment already employed. We therefore do not know whether the patients' noted improvement in weight, anorexic symptoms and psychological functioning extend to improvements in the patients' social functioning and relations.

Overall while MFT appears to be a promising approach for the treatment of adolescent anorexia nervosa, more research is needed in the form of Randomised Control Trial (RCT), conducted with a larger sample and including more severely ill patients that also addresses social, physical and psychological functioning and employs longer follow-up periods in order to be able to draw more comprehensive conclusions about the treatment's efficacy.

There is scope for comparing MFT with single family therapy, found to be effective in the treatment of adolescent anorexia nervosa, as well as other treatment modalities, such as specialist inpatient care, commonly used with this patient population. Along these lines, comparisons could be aimed at identifying which treatment, if any, produces better and/or quicker therapeutic effects as well as cost effectiveness and patient/family satisfaction.

11.2) FAMILY VARIABLES IN MFT: change and relation to outcome

a) Do family factors change during MFT?

The results of this study have indicated some change in terms of the parents' measures of family life (EE) and depression (BDI). More specifically, both maternal and paternal depression levels improved significantly by the 6 months follow-up. This however, is of less clinical relevance as compared to the patients' given that parents, and especially fathers, did not appear to be particularly depressed, in the first instance, in stark contrast with the patients most of whom where within clinical depression levels at the beginning of the study.

It is also interesting to note that the reduction in maternal levels of depression took place between the 3 and six months follow-up. This might be accounted for by the fact that most of the patients had shown substantial improvements, in terms of weigh gain, by 3 months. It is therefore possible that reduction in maternal depression was, at least partly, facilitated by their children getting better.

In terms of the parents' EE towards their ill relative, the results indicated some changes over time occurring in both mothers and fathers with Critical Comments, Emotional Over-involvement and Hostility reducing during treatment while Positive Remarks and Warmth increased. Nevertheless the changes were very small. The only rating that changed significantly was paternal CC.

The finding of reduction in parental criticism is consistent with previous reports of anorexia nervosa families undergoing a family intervention (Eisler et al., 2000; Le Grange et al., 1992b). Most results were also in the expected direction with respect to changes between parents' EE. Levels of criticism reduced for mothers to their partners though slightly increased from fathers to mothers, hostility between parents increased as did warmth and positive remarks. Again, change over time across variables was very small with maternal warmth towards the father being the only variable that was found to change significantly.

The present finding of increases in warmth between the parents is consistent with previous findings of family therapy (Dare et al., 2001; Le Grange et al., 1992b) irrespective of whether it is conjoint (parents and patients seen together) or separated (patient seen separately from parents). This is possibly accounted for by the fact that a family intervention, of any sort, provides an opportunity for joint involvement in the care of their child as well as increased support and communication between them; resources that the family might possess but that might have become less accessible due to the emergence of the illness.

With respect to the amount of change in perceived family functioning during MFT, the SFI results were not always in the expected direction with maternal and paternal SFI levels increasing by 6 months while only patient scores decreased. Changes over time however were extremely small and did not reach levels of statistical significance.

The finding of lack of change in SFI scores was in contrast with Beavers et al's reports (Beavers & Hampson, 1990; Hampson & Beavers, 1996b; Hampson & Beavers, 1996a)

indicating the SFI as a sensitive instrument measuring and/or predicting change during the course of family therapy. However, although the above reports have included, amongst others, anorexic patients in their study populations, results are not presented separately for that patient group which might explain the discrepancy between the present findings (and/or lack of findings) on the SFI and those reported by Beavers.

Another relevant point for consideration is that previous studies employing self-report methodology to assess family functioning during family therapy for adolescent anorexia nervosa, found the discrepancy between perceived and ideal scores (i.e. dissatisfaction with family life) to be of most relevance to treatment response rather than scores on perceived family functioning per se (Eisler et al., 2000; Le Grange et al., 1992b). These studies have employed the Family Adaptability and Cohesion Evaluation Scales (Olson, et al., 1979a;1979b) which, in contrast to the SFI instrument, also assess family dissatisfaction. Therefore, the SFI despite its good psychometric properties and predictive value of family therapy outcome in various clinical groups might not be sensitive enough to and/or addressing the issues of relevance (e.g. family dissatisfaction) to anorexia nervosa patients.

Also consistent with other studies, this study has shown, at the descriptive level, that overall levels of parental EE are relatively low even prior to the treatment (Eisler et al., 2000; Le Grange, 1989; Le Grange et al., 1992b; Van Furth et al., 1996). More specifically, parents tended to score (both towards the ill relative as well as towards each other) low on criticism, hostility and EOI while they tended to have moderate scores in the Warmth scale; parental scores on Positive Remarks, also tended to be low. As for the SFI, both parental

and patient scores were within normal levels indicating thus, at least adequate, family functioning.

Therefore, baseline scores of family functioning (EE & SFI) in this study, with the exception of the Positive Remarks variable, left little room for improvement and have possibly introduced a *floor effect* that might account for the lack of significant change over time in most of the family functioning variables. Nevertheless, it is interesting that despite the low levels across all family measures some of them seemed to improve while others, especially the SFI, remained unchanged. Overall, initial predictions were partly supported by the results with most family measures changing towards improvement.

b) Are family factors related to patient symptomatic outcome?

Interesting results have also emerged from the analyses on the association between family factors and patients symptomatic improvement. At the initial analyses, the variables of maternal BDI, and paternal criticism, EOI and warmth were found to be significantly associated with outcome. A reduction in maternal BDI and paternal CC and high levels of paternal EOI and Warmth at baseline being associated with a better outcome in terms of the patients' weight. Expressed emotion between the parents and SFI were not found to be associated with the patients' outcome.

The high number of tests conducted (one for each independent variable; n= 22 tests) as well as the fact that these were conducted for each variable without adjusting for the possible effect of the other variables increase the probability of a Type I Error, that is, accepting a chance finding as statistically reliable. Therefore, these series of analyses

although useful at an exploratory[12] level should not be seen as representing the main findings of the present study.

The variables found to be significantly associated with the patients' average body weight in the definitive analyses, and after adjusting for the effect of the other variables included, were paternal CC and EOI towards the patient. Similarly to the exploratory analyses, a reduction of paternal CC during MFT was related to a better outcome. As for the EOI variable, in that instance it was its change level that was found to be associated with outcome with increases in paternal EOI over time being associated with a better outcome on the patients' weight.

The role of parental criticism in predicting outcome of family therapy in anorexia nervosa has also been demonstrated in previous studies with high CC at baseline being associated with poor outcome (Eisler et al., 2000; Le Grange, 1989; Le Grange et al., 1992b; Van Furth et al., 1996) and dropping-out of treatment (Szmukler et al., 1985; Le Grange et al., 1992; Eisler et al., 2000) while falling parental criticism was also associated with good patient outcome (Eisler et al., 1997; 2000; Le Grange 1989; Le Grange et al., 1992). In this study however, parental CC at baseline failed to predict patient outcome and this was the case even in the exploratory analyses.It was only change in terms of reduction of CC that was found to be a strong predictor of patient outcome with this being the case for paternal CC scores only.

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[12] Aimed at the detection of variables possibly contributing to outcome and to be included in the definitive multiple regression model.

It is interesting to note here that parental criticism, despite its low levels in anorexia nervosa families, is consistently found, this study included, to have a negative effect on patient outcome. One speculation about that involves the possible over-sensitivity of anorexic patients to criticism however little this might be, with this over-sensitivity relating to the patients' sense of ineffectiveness as consistently indicated by their low self-esteem scores (e.g. Le Grange et al., 1992). In that instance, even minor criticism is seen as further triggering the patient's sense of worthlessness and ineffectiveness which has been linked to body image dissatisfaction (Geller et al., 1997;1998) making him/her find resort to his/her starving behaviour as the only area where perceived success and control over one's life is possible.

An alternative explanation of the negative effect of even few critical comments on the patient's outcome would involve the quality rather than the quantity of criticism. In other words, despite not making a lot of critical comments, parents of anorexic patients might instead make a few CC that are nevertheless particularly hurtful for the patient. This however was not examined in the present study.

The relationship between high EE at baseline and dropping-out of treatment has not been empirically addressed in this study, partly due to the very small attrition rates (n=2 families). The association between increasing levels of parental EOI and better outcome is a finding somewhat more difficult to interpret especially given that in the original studies of EE in families of schizophrenia patients high EOI families were found to have an effect, equally toxic for the patients' relapse as that of high CC (see Wearden et al., 2000 for a

review). A similar relationship between higher EOI (as a continuous variable) and worse outcome was reported for anorexia nervosa (Van Furth et al., 1996).

Along these lines the finding of the present study regarding the relationship between increasing paternal EOI and positive patient outcome somewhat resembles findings in other conditions including borderline personality disorder (Hooley & Hoffman, 1996) and diabetes (Stevenson et al., 1991) where high parental EOI was associated with better symptomatic outcome in terms of relapse/re-hospitalisation and glucose control respectively.

The direction of association between EOI and outcome in this study, however, should not be seen as implying that the higher the EOI the better the outcome. Parents in this group, as opposed to the personality disorder and diabetes studies mentioned above, were characteristically low in the EOI variable and it is therefore unclear whether high EOI levels in parents of anorexic patients would relate to better outcome, as in the personality disorder and diabetes studies, or would rather have a toxic effect similar to that demonstrated in the schizophrenia studies.

One possibility could be that in adolescent anorexia nervosa EOI has a curvilinear relationship to outcome with the too little and/or too much being counterproductive and a certain degree of parental involvement facilitating weigh gain. This is consistent with studies of family therapy suggesting that interventions where parents are encouraged to actively take control over the child's eating are more effective than those promoting support and co-operation (Robin et al., 1995). It might be the case that in order for families

to be able to help their children towards recovery, parents might have to temporarily increase behaviours (such as involvement in diet plans and meal times as well as preventing the patient from engaging in compensatory behaviour) that would otherwise be seen as high EOI.

The above explanation, although persuasive fails to account for the discrepancy between the findings in the present study and the Van Furth et al., (1996) study with the former showing a positive effect of EOI on outcome and the latter a negative one. With this respect it is worth noting that EOI is a composite measure taking into account different aspects of the relative's response style including exaggerated emotional response, self-sacrificing behaviour, intrusiveness and over-protectiveness. Although evidence of all of the above qualities during the interview contributes to the rating of EOI they may have a differential effect on outcome in adolescent anorexia nervosa. Therefore, relatives with the same and/or similar rating on the EOI scale may differ with respect to their specific quality and/or way of being over-involved. The currently used EOI rating does not discriminate between those differing qualities of over-involvement.

Another possibility to account for the finding of a positive effect of increasing paternal EOI is its high positive correlation with warmth identified in the baseline measures of this study which is also consistent with the schizophrenia literature (Brown et al., 1972). It could thus be argued that the effect of EOI found in this study is a statistical artefact representing the positive effect of warmth rather than of EOI. However, given this high correlation it would equally be expected for EOI (if it had a negative and/or neutral effect on outcome) to mask the effect of warmth rather than for warmth to amplify the effect of EOI. This has been

found to be the case in families of patients with schizophrenia where it is only in the absence of EOI that warmth has a positive effect on outcome (Brown et al., 1992). It is therefore more likely for the positive association between paternal EOI and patient symptomatic outcome to reflect an actual association between the two, at least for the families in this study, rather than a statistical artefact.

At this point it should be noted that in a substantial number of EE studies (see Wearden et al., 2000) especially in the schizophrenia literature relatives tend to be categorised as high EE on the basis of being high in CC or EOI or both on the grounds that the presence of any of these constructs as well as a combination of both is detrimental for the patient's outcome. The present study on the other hand has indicated that there might be a differential effect of CC and EOI in recovery from anorexia nervosa. Therefore, studies looking at the effect of EE upon this patient population that, unlike the present study, use EE levels as a categorical variable, should possibly deal with EE and EOI classifications separately (e.g. High CC, High EOI, or High both CC and EOI) rather than merging relatives in the general category of High EE.

The results on the association between family variables and patient symptomatic outcome have partly supported original predictions in that, some, yet not all, family measures were found to be associated with the patients' symptomatic outcome. Patients' increased weight was most strongly associated with decrease in paternal CC and some small increase in paternal EOI towards the patient.

Nevertheless, there are a variety of issues that need to be considered before drawing conclusions about the effect of family factors upon symptomatic outcome in anorexia nervosa. One such problem is a limitation common to EE studies. Namely, that although the significance of the construct in outcome has been demonstrated for a variety of conditions, anorexia nervosa included (Wearden et al., 2000) a causal direction has not been empirically shown. In other words, it might also be the case that changes in EE are purely a result of the patients' improvement, especially given that criticism is found to increase when anorexia persists (Le Grange et al., 1992).

A relevant speculation would be that the relationship between EE and outcome is a circular rather than a linear one. That is the less critical, for instance the parent is, the more able he/she is to be helpful in the process of his/her child' s recovery while the patient getting better contributes to further reduction of criticism. Similarly, while the parents' attempts towards re-feeding his/her child prove ineffective by the patient loosing and/or not gaining weight the more ineffective the parent feels and the more critical he/she becomes towards the patient entering into a vicious circle that inhibits recovery.

Another problem in drawing conclusions is that possible confounding clinical and demographic variables were not entered in the analysis. It is therefore unclear whether the relationships between EE and outcome would persist if the possible effect of those variables upon outcome was adjusted for by their inclusion in the relevant analyses. With this respect it should therefore be noted that the present results have indicated which of the family variables assessed have been found to be most strongly associated with patient

symptomatic outcome, without postulating that their effect is over and above the potential effect of illness related and other variables.

11.3: IMPLICATIONS FOR ANOREXIA NERVOSA FAMILIES

So far, the results of the present study have been discussed also taking into account their comparability with previous relevant research. In this section an attempt will be made to bring those together and try to explore the bigger picture of processes within families containing an adolescent suffering from anorexia nervosa.

This will be done by addressing how well the present findings fit to earlier clinical descriptions of family systems theorists (Minuchin, 1975; Minuchin et al., 1978; Selvini-Palazzoli, 1970;1974; 1988) that have been ever so influential in the development of explanatory models and treatment approaches. This issue will also be addressed by taking into account the similarities and differences between the two instruments (EE & SFI) employed in this study to assess family functioning. Lastly, the possible differential effect of the different caregivers (i.e. mothers Vs fathers) in the recovery process will be explored.

a) Present results and early anorexia nervosa formulations

As discussed previously the EE results of the present study along with those reported by previous authors (Eisler et al., 2000; Hodes & Le Grange, 1992; Le Grange, 1989; Le Grange et al., 1992a; 1992b; Szmukler et al., 1985; Van Furth et al., 1996; Wearden et al., 2000) provide a relatively consistent picture of anorexia nervosa families as being characterised by lack of overt affective expression either in the form of disagreement and

dissatisfaction (i.e. CC & Hostility) as well as in the form of praise, appreciation and affection (warmth and positive remarks).

Dare et al., (Dare et al., 1994) have addressed these findings regarding the extent to which they fit to the early descriptions of anorexia nervosa families placing particular emphasis on Minuchin's model of the psychosomatic family. With this respect they viewed the consistently emerging lack of criticism and hostility as reflecting the early postulated muted and conflict-avoidant response style of these families which along with lack of warmth and positive remarks also signals a degree of rigidity, in the sense of a limited and narrow repertoire of transactional patterns described to exist within anorexia nervosa families (e.g. Eisler, 1988; Minuchin, 1975; Minuchin et al., 1976).

Lack of high levels of warmth and positive remarks, especially in the absence of criticism have also been described as an alternative way for anorexia nervosa families to exhibit criticism and dissatisfaction while maintaining their muted response style (Le Grange, 1989). Still, if lack of warmth is indeed reflecting a critical attitude and given the negative effect of high levels of parental criticism on patient outcome one would possibly expect to find a similar effect of low levels of warmth upon outcome which does not tend to be the case.

So far, the results of the present study along with those of previous studies seem to provide a description of anorexia nervosa families which is similar to their portrayal by early family therapists with respect to a prevalent response style which is lacking in expressiveness while also not being tolerant of conflict.

However, an additional set of qualities thought to be characteristic of eating disordered families involves enmeshment, over-protectiveness and lack of boundaries (Minuchin, 1975; Minuchin et al., 1978; Selvini-Palazzoli, 1970; 1974; 1988; Stern et al., 1981; Stierlin, 1981; Stierlin, 1983; Stierlin & Weber, 1989a;1989b).

Dare and colleagues (1994)drew a parallel between those concepts and that of EOI while signalling caution to the only superficial resemblance between EOI and enmeshment. The former mainly referring to parental behaviour of exaggerated emotional response, intrusiveness and overprotection and the latter representing a more internal cognitive process characterised by lack and/or desire for lack of boundaries between family members, including the parent-child sub-systems. In any case families of anorexic patients appear both in the present and in previous studies (Eisler et al , 2000; Hodes et al., 1992; Le Grange, 1989; Le Grange et al., 1992a; 1992b), to lack the qualities of enmeshment and over-protectiveness as shown by their low EOI scores.

Nevertheless, the positive effect of increasing paternal EOI upon patient outcome shown in the present study might bear indirect support for another aspect of the early clinical descriptions; namely the detached and/or emotionally unavailable father who if more involved with the adolescent contributes to a better symptomatic outcome. This however, needs to be seen with caution firstly because it is only an indirect, inductively oriented speculation and secondly because of lack of consistent findings supporting this relationship between EOI and outcome.

Overall, the results of the present study along with previous findings provide some support for the early family systems formulations. Nevertheless, this is at the descriptive level only. That is what the families look like when presenting to services. This can not automatically be assumed to have been part of the families' interaction prior to the onset of the illness, let alone to have played a role in its development.

As such, EE findings in anorexia nervosa, including the ones reported here, cannot be seen as confirming the early ideas postulating that dysfunctional family patterns have preceded and possibly contributed to the development of the illness. As discussed in an introductory section of the thesis addressing the issue of "what caused what" is beyond the scope of the present investigation. This is on the grounds of lack of consistent findings differentiating eating disordered families from controls, making the quest for causes within the family similar to a "chicken- and- egg situation" which as such becomes futile and misleading (see introduction).

Along these lines it might worth considering some of the alternative explanations offered about the parents' reluctance/difficulty in expression of emotion, particularly criticism towards their ill child. These seem to be moderated by illness related characteristics and/or associated behaviours rather than represent the family's own and inherent style of interaction.

One such possibility, as postulated by Hodes and Le Grange (1992) in a relevant review, is that the emaciated state and fragility of the anorexic patient might prevent the expression of

parental dissatisfaction, criticism and conflict by giving rise to a protective response instead.

Clinical experience also demonstrates that parents, as a result of the emergence of a serious illness like anorexia are quite reluctant to express any opinion and/or emotion in fear and anticipation that any contribution of that sort and despite their good intentions might make things worst for their ill child. Therefore, the parents attempt not to "rock the boat" might also contribute to their lack of expressiveness of negative as well as positive feelings

Furthermore, the successful dieting and associated ability of self-control may be highly admired by parents as signs of strong will power. This is particularly the case for mothers especially given that mothers of anorexics are more likely to have themselves successfully and/or unsuccessfully dieted than are those of controls (Gershon et al., 1983) in which case parental attitudes about the anorexic's not-eating may well escalate from admiration to envy (Hodes et al., 1992).

The above explanations, although persuasive in accounting for the lack of expression of criticism fail to address the bigger picture emerging by EE studies presenting families of anorexics as un-expressive across all levels of expressed emotion. It is therefore possible that the emaciated state of the patient, and his/her admired self control, complement rather than explain, the parents' lack of criticism.

b) Insiders' Versus Outsiders' views of the family: Competing or complementary perspectives?

In the previous section the implications of this study, at the descriptive level, for anorexia nervosa families have been discussed based on the study participants' EE levels. This section will attempt to address this issue by also including findings, or actually lack of findings, in the SFI instrument.

On one level the parents' low scores on the EE scales as well as mid-range scores obtained by all family members in the SFI instrument can be seen as an indication that no family pathology is to be found within those families, especially given their consistency across all three times of assessment.

However, as discussed above the characteristically low EE levels can be seen as providing some support, though indirect and without implying causality, of dysfunctional family interaction in anorexia nervosa families, most probably arising as a response to the illness yet somewhat inhibiting the process of recovery.

The SFI, on the other hand is an instrument assessing the themes of happiness, optimism, problem-solving and negotiation skills, family love, strength of parental coalitions, autonomy/individuality and minimal blaming/increased responsibility patterns. In this instrument family members' scores indicated at least adequate family functioning while the striking thing was the almost non-existent amount of change in the instrument as well as its entire lack of effect upon the patients' outcome whatsoever.

At one level the results of the study on the SFI might be seen as indicating that these families seem to operate at a good level which in a sense disproves the idea of family dysfunction within anorexia nervosa families. This finding though, is somewhat counter-intuitive as clinical experience demonstrates that, usually, at least some of the above mentioned areas of family life are compromised by the emergence of an eating disorder. One could possibly argue that these families were functioning even better prior to the onset of the illness and the scores obtained represent some compromise yet not reaching dysfunctional levels. As no scores on the SFI prior to the anorexia are available this hypothesis could not be tested. Nevertheless, if this was the case it would be expected that SFI scores would partly improve as a result of the improvement found in most patients. This however was not the case.

Furthermore, it is the EE scores of those same families that depicted them as lacking in affective expression. An obvious question that therefore arises is how is it possible for families, found reluctant to express criticism and dissatisfaction on the one hand (i.e. CC), engage in problem-solving and negotiations (SFI). Similarly, how is it possible for families who are relatively low in terms of warmth and positive remarks (EE) to score positively in the qualities of family happiness, optimism and family love (SFI). Although the above levels assessed by EE and SFI are, somewhat, conceptually different one would expect that they would tend to go hand in hand as far as family interaction is concerned. In other words, some degree of expression of criticism and dissatisfaction would be involved in family negotiation and problem solving and some degree of expressed warmth and appreciation would contribute to family members feeling close to and loved and appreciated by each other.

A possible explanation lies in the fact that because warmth, for example, is not overtly exhibited during a family interview does not necessarily imply that it is not exhibited in the family home or alternatively that family members may need small, yet significant to them, signs of warmth to feel loved and appreciated. In other words the discrepancy of findings can possibly be a result of the discrepancy between an instrument that is observer rated (EE) and one that is self-report (SFI). As Beavers and Hampson put it, this problem *"is not alike the proverbial forest and trees: a rater within the forest can offer certain perspectives on the plot that an observer flying over could not gain; likewise, the overhead observer can gain perspectives on the score and size of the forest that the 'insider' may not have" (Beavers et al., 1990).*

This insider-outsider perspective constitutes a valuable argument indicating that none of the two views is the objectively accurate one while both of them offer different insights with their respective strengths and weaknesses. To name but a few, a family interview offers the opportunity to observe the families at a system level including the interactions taking place between family members' sub-systems while having the obvious shortcomings that these interactions, occurring within a research and/or clinical setting, can not be assumed to be the same in the family's own environment (e.g. the family home and/or other situations such as social activities naturally occurring in the families' life).

Similarly, no matter how well standardised the instrument and how well trained the ratter, the family interview is automatically introducing a new system, one in which the interviewer is part of. The unavoidably different style of different interviewers may have an

impact on how the family members engage with each other as well as with the interview procedure during assessment. As for self-report of family interaction, it is valuable in offering the insider perception of family members; nevertheless, system properties including kind, style and quality of interaction between family members is difficult to be captured in questionnaire items.

The question of which one of the two methods is closer to the actual truth of the family is possibly a futile one as they seem to address two different perspectives both of which are valuable but none of them objective. On this premise it could be argued that the EE and SFI findings of this study reflect the difference between how families are perceived by the 'outsider' researcher and the family members' own, 'insider's' perception.

What therefore emerges in this study is that families perceived as affectively muted and conflict avoidant tend to view themselves as affectionate towards and close to each other, optimistic about family life and capable to engage in processes of negotiation and problem-solving, usually requiring a certain degree of expressiveness of feelings, ideas and disagreements.

In Beavers's formulation this would appear to be a discrepancy in the families *"mythology"* (Beavers et al., 1990) referring to the extent to which the family's concept of it self is congruent with that of an outside observer. In other words, in this study, the families present themselves in the interview quite differently from what they themselves perceive to be like as shown by their replies in the items of the SFI.

In this respect, it worth noting that a self-report instrument assumes that respondents have the level of insight required in order for their behaviour and/or affect to be reflected by their answers to the questionnaire items. Although this can be the case for instruments assessing symptomatic behaviour (e.g. BDI), it might become more complicated when it comes to family interaction. For example, if a markedly over-protective parent was asked to rate his degree of over-protectiveness and involvement he/she might lack the insight needed in order for this quality to surface as a response to a questionnaire item. This is possibly because this parent would tend to perceive his/her behaviour as a reflection of genuine interest in and reasonable concern for their child rather than as age inappropriate, over-protective and/or intrusive. As Dare and colleagues (1994) put it with respect to Minuchin's (1974; 1978) concept of rigidity as conveyed by the FACES questionnaire *"a self-report instrument makes the assumption that family members can make the relative judgements that are needed but the more rigid the family the less likely they are to make use of external referents that make such judgements possible"(Dare et al., 1994; p.221)*

Along these lines, it is possible that the families' inhibited expression of emotion, as indicated by their low EE scores, prevented them from making that apparent in the self-report measure. In other words, both an expressive and an un-expressive parent might give the same reply on SFI items such as "we all have a say in family plans" however, their overt behaviour might be very different with the former parent arguing his/her view and preference over a family holiday for instance, and the latter simply saying that he/she would go along with whatever the family decides. This represents a difference of perception between the two parents on what is meant by "we all have a say". With this respect an un-expressive parent would perceive questions about warmth and/or

disagreement differently from an expressive one purely due to their different levels of tolerance of overt affect and emotion. The same would possibly be the case for an adolescent from a less expressive family perceiving as a full-blown argument what one from a more expressive background would hardly view as a benign disagreement. Therefore, the SFI scores obtained in this study might have been partly coloured by the families affectively muted response style indicated by their EE scores.

Nevertheless, these speculations are difficult to substantiate in the present study. One should probably more parsimoniously conclude that the different picture emerging from the EE and SFI rather reflect their difference of perspective (i.e. insider Vs outsider) with the outsider perspective proving to be more amenable to change and of more relevance to patient outcome.

c) Are fathers more important than mothers?

Another implication associated with the present results involves the importance of fathers in the recovery process of adolescent anorexia nervosa patients. More specifically, with respect to parental EE variables towards the patients the ones found to be statistically significant with respect to change during treatment and predictive value for outcome were paternal CC and EOI respectively. None of the maternal EE variables, towards the patient, reached significance either as associated with outcome nor as changing during treatment. This might be reflecting a different effect of EE levels between mothers and fathers upon the patients' recovery process and the potential of paternal EE of being of more, or at least similar, importance to that of maternal EE.

Having said that though, the problems in drawing such a conclusion from the results of the present study need to be discussed. The main such problem is that maternal and paternal scores in CC and EOI were, not surprisingly, in the same direction while they also tend to be highly correlated. Therefore, a high degree of overlap exists between maternal and paternal EE scores making them hard to differentiate statistically. That is, in statistical terms, some degree of paternal EOI and CC is also conveyed by maternal scores in these variables and Vice Versa. Thus, the possibility of the present findings to reflect a true difference in the degree of change and/or association with patient outcome between maternal and paternal scores is similar to the possibility of this finding being primarily accounted for by paternal mean scores showing only a slight degree of more change/association with outcome possibly attributed to a few outlier scores influencing group means. Therefore, caution is needed before interpreting this finding as reflecting a true differential effect between the carers.

Nevertheless, the above finding is important in highlighting that fathers are, at least, as important as mothers during the process of recovery with this having important implications for their inclusion in both treatment and research. The former will be addressed in the following section. With respect to the inclusion of fathers in EE research it worth noting that there is large variability between studies interviewing and rating all household members and those who select, on theoretical grounds, the less time-consuming approach of concentrating on the key relative (usually the mother) on the assumption of having the greatest impact on the patient (Wearden et al., 2000).

The results of this study can be seen as demonstrating that this assumption, at least in the condition of anorexia nervosa, is a false one. The question that therefore arises is what makes paternal scores equally and/or more amenable to change (CC) as well as of similar and/or more significance to outcome (EOI) as compared to those of mothers who are indeed the key carers.

A possible explanation with respect to CC might be that mothers, usually being responsible for the care of their ill child and ever so often being the ones involved in activities who take a largely confrontational nature in households of anorexia nervosa patients, such as mealtimes and food shopping. As a result, the patient might have in a sense, become used to maternal criticism when it emerges and thus more able to ignore it. In other words, some degree of criticism might have become part of the mother-patient habitual interaction during anorexia. In this respect, paternal criticism might come as more salient and unexpected and as such having a more profound effect upon the patient.

As for the EOI's impact on outcome one possibility relates to the idea of it representing the emotional unavailability and marginalisation in family life discussed previously. In that instance emotional unavailability refers to the perceived rather than the actual level. Fathers of anorexic patients encountered in clinical settings often appear detached and unavailable while in essence being as distressed and worried as the mothers, only they are reluctant to be actively involved in the patient's care in order not to interfere with what, the already over-worked and severely burdened mother is doing. This is often perceived by patients as lack of care and interest on behalf of their fathers while mothers feel unsupported by their partners. Taking into account this, so often encountered clinical picture, the small increase

in paternal involvement might operate by making patients feel more cared for and mothers more supported and less burdened.

Another different, yet complementary possibility, is that paternal involvement might be more effective, at the practical level of making the patient eat more and/or induce less weight controlling behaviours. This might be the case either because of fathers stereotypic portrayal as the decision makers of the house and/or due to the fact that their strategies come as more salient and unexpected for the adolescents who finds it difficult to endlessly negotiate and/or play around with; a practice that becomes habitual with the more involved carer, usually the mother.

The above speculations, although clinically sensible, need to be seen with caution in the present study partly because of the statistical overlap between maternal and paternal EE scores discussed above as well as due to the lack of such a differential effect in previous studies in anorexia nervosa.

Another relevant issue involves the limitation of the EE instrument to capture interactional patterns of EE between relatives. In other words, the EE rating does not discriminate, for example, between a family in which when one relative becomes critical the other joins in the criticism, a family where both relatives are critical and a family where, when one relative becomes critical the other tends to be protective of the patient. There is one study that has gone a bit further in that direction in families with patients suffering from schizophrenia. Goldstein (Goldstein et al., 1989) compared families where there were either two-low EE parents, two high-EE parents or one low- and one high- EE parent. Not

surprisingly, they found that the expression of criticism from both patients and relatives was greatest in the "consistently high-EE" families. Also, relatives' groups in psychosocial interventions for schizophrenia provide some indication that having low-EE relatives in the group might moderate the effect of high EE relatives (Leff et al., 1982). In instances like that, high EE-relatives may acquire positive coping strategies being influenced by their low-EE counterparts while there is a possibility of similar process taking place in naturally occurring groups including families." (Wearden et al.,2001). Still, so far we have only a tiny fraction of the bigger picture of the variety of ways in which EE can be expressed within a family and its possible role in the patient's outcome.

It therefore appears that a differential effect of the role of mothers and fathers in the patients' recovery is not easy to establish. Nevertheless, the results of the present study show that fathers, the role of whom is sometimes overlooked, both in research and clinical practice, seem to have an effect similar to that of the mother, to say the least. It still remains very difficult to understand the various ways in which EE may operate within a family and how ways of EE being expressed by one carer might moderate the ways in which it is expressed by the other carer.

11.4: IMPLICATIONS FOR MFT IN ADOLESCENT ANOREXIA

NERVOSA: family changes and patient/family satisfaction.

The findings on the patients' outcome and the families' change during the MFT treatment have been addressed in the previous sections of this chapter and will not be repeated here. This section would rather be devoted to the discussion of some of the findings that stand

out as somewhat salient when viewed under the light of previous studies of family therapy in anorexia nervosa.

One such finding relates to the patients' symptomatic outcome which, although comparable to previous results (e.g. LeGrange et al., 1992; Eisler et al., 2000), seems to be achieved faster within the context of the MFT with the patients' weight gain at six months being comparable to that achieved at one year in previous studies.

This might relate to the more intensive nature of the MFT approach, consisting of an initial four whole day therapeutic input compared to weekly or fortnightly one hour meetings of traditional family therapy. This intensity of the MFT might be facilitating and thus accounting for the rapid weight gain.

Also, contrary to previous findings(Eisler et al., 2000; Le Grange, 1989; Le Grange et al., 1992b; Szmukler et al., 1985) high levels of CC at the beginning of treatment were not found, in the present study, to be predictors of a worst outcome and dropping-out from treatment. The lack of such an association in the present study might possibly be reflecting a protective factor of the MFT context for initially highly critical families. In other words, high levels of parental criticism at the beginning of the treatment might somehow have been managed and/or contained during the MFT treatment not making those families prone to worst outcome and/or drop-out.

An alternative explanation would be that relatives in the present study were less critical in the first place and as such less prone to the negative effect of high levels of CC. This

however, does not seem to be the case since, as discussed previously, the levels of parental criticism in this study were consistent with previous studies (e.g. LeGrange et al., 1992; Eisler et al., 2000) indicating low levels of CC.

Another explanation could be that by the time the data for this study was collected the negative effect of parental criticism in the outcome of anorexic patients was well established while a large number of the relevant findings have come from studies conducted in the same clinical facility where the present study was conducted. It is therefore only fair to say that clinicians conducting the MFT treatment were well aware of the link between parental criticism and patient outcome as this has been established by themselves and/or their colleagues. Therefore, clinicians in this study might have been particularly alert to critical families and consciously directing part of their therapeutic efforts in engaging families who appeared to be more critical. Hopefully, this indeed was the case and possibly has partly contributed to CC reduction and lack of drop-outs. However, it is unlikely that this was solely a function of therapists' variables; this would overlook other factors of the MFT context as a whole.

The high ratings of patient/family satisfaction with treatment were another interesting finding. Patients were significantly less satisfied with the treatment than their parents were; nevertheless, both patients and parents rated the treatment favourably as indicated by their CSQ scores. This is further complemented, albeit indirectly, by the very low rates of dropping-out of treatment.

There are various problems with patient satisfaction ratings, extensively discussed in an introductory section of the thesis, the main of them being uniformity in ratings of high patient satisfaction across the various patient groups and across various treatments with this possibly highlighting a problematic methodology. However, the relevant findings of the present study are in stark contrast to the dissatisfaction with family therapy expressed by eating disorders patients (Newton et al., 1993; Rosenvinge & Klusmeier, 2000;) while being consistent with preliminary reports of high satisfaction with the MFT treatment (Asen et al., 2001; Asen, 2002; Dare & Eisler, 2000). Therefore, and despite the problematic methodology of client satisfaction questionnaires there seems to be, at least, some genuine satisfaction with the treatment reflected in the present findings.

What therefore emerges is that apart from the faster weight gain observed in MFT there are some other benefits found to occur during this treatment modality that are not associated with the traditional form of conjoint family therapy. One such potential benefit involves the possibility of MFT to operate in a protective manner for those parents starting off being more critical. Also, increases in paternal EOI within MFT were found to have a positive effect on patients' symptomatic outcome, though as noted earlier, this finding should be regarded with caution. Despite that though, there still remains possible for some fathers to have got more involved with the care of their children during MFT in a beneficial way. Similarly, high patient/family satisfaction was reported for the treatment and possibly the two factors (EE and client satisfaction variables) are somehow related. This will be addressed at a later point in this section.

In trying to understand potential processes during family interventions that facilitate the documented EE improvement, it worth considering factors found to be related to EE. One such line of research, conducted upon families of patients with schizophrenia, involves the relationship between relatives' EE and causal attributions. With this respect, studies have consistently indicated a relationship between EE and perceived locus of control with highly critical relatives attributing the patient's behaviour to factors personal, idiosyncratic and within the patient's control while those relatives who were high in EOI tended to attribute the patient's behaviour to factors universal, non idiosyncratic and outside of the patient's control which were similar to the attributions of low CC relatives (Barroclough et al., 1994; Brewin et al., 1991; Weisman et al., 1993).

Another relevant line of research, conducted upon anorexia nervosa patients that also addressed the parents' views on their own role in the illness involves Self-And-Other-Blame, found to be associated with parental criticism. More specifically, parents of anorexic patients who are self-blaming about the onset and/or maintenance of their child's illness tend to also be more critical of their child as well as more blaming of him/her. Similarly, patients from highly critical families also tend to be more blaming of their parents with respect to their illness than patients form non-critical families (Besharat et al., 2001).

It therefore, appears to be a dynamic relationship between where illness related behaviour is attributed to, self/other blame and criticism. Taking that into account, a possible description of family process in anorexia nervosa involves self-blaming parents criticising and also blaming the patient for his/her illness related and possibly other behaviour who in turn

retaliates by blaming the parents, further contributing to their self-blame and so on and so forth. This possibly contributes to both the parents' and the patients' sense of ineffectiveness further compromising the formers', already weak belief in their ability to help their child, while the patient reverts more into his/her anorexic symptom. The family's resources instead of being mobilised and directed towards the recovery process become paralysed by this vicious cycle, possibly further maintaining the illness. With this respect one of the treatment's objectives should be to break this circular process in order for the families to gain or re-gain access to their family resources.

It is interesting at that point to note that one of the explicit goals of both MFT (Asen et al., 2001; Asen, 2002; Dare & Eisler, 2000) and family therapy models (Dare & Eisler, 1995; Dare, 1983; Eisler, 1995; Lock et al., 2001;2002) is to directly address feelings of guilt and blame as well as critical attitude on the parents while presenting the anorexic symptoms and behaviours as something uncontrollable from the patient (often through techniques of externalisation where the illness portrayed as an entity that has taken over the patient). In this respect parental criticism seems to drop in both the context of the MFT and the more traditional family therapy. As noted earlier it is unclear whether this is a direct function of the treatment(s) or whether reduction in parental criticism comes as a result of parent improvement. As discussed previously it is more likely that changes go hand in hand and influence each other in a circular way.

Nevertheless, MFT appears to be more successful than family therapy in containing and managing parental criticism as indicated, in this study, by the lack of-drop-outs (including high EE parents found more prone to discontinue treatment) as well as by the lack of

association between high CC at baseline and outcome. In other words, the MFT approach seems to have a protective function for those families who might be expected to do poorly either in terms of lack of patient improvement or by dropping out of treatment. Given the similarities between the two treatments (MFT and family therapy) one is tempted to consider their differences in order to understand what are the possible ingredients of MFT prevent parental criticism from exercising its negative effect.

The main differences though mainly involve treatment context rather than content. Firstly, as noted earlier, MFT is more intensive which might make the relevant therapeutic interventions to have a higher impact taking place for four consecutive whole days. Similarly, the difficulties in engaging families where there is criticism have been documented (Szmukler et al., 1995; Le Grange et al., 1992; Eisler et al., 2000) and discussed (e.g. Dare et al., 1994; 1995) at various instances in the literature. Overall it appears that it remains a challenge for these families to 'tolerate' family interventions and for family therapists to find ways of engaging them. This has been attributed to the confrontational nature of family interventions (e.g. Dare et al., 1994; 1995) as well as feelings of quilt and blame associate with that type of therapy (Squire-Dehouck, 1993). In this respect, the presence of other families, with similar experiences, as is the case in the MFT setting might be determinant for the containment of feelings of quilt, blame and criticism in a way that can not be possible in the customary family therapy. Similarly, due to the presence of the group, the therapist(s) may adopt a somewhat different, role. As Asen (2002) suggested, in the MFT setting the role of the therapist is to act like a 'catalyst' facilitating group cohesion. This, somewhat discrete, role of the therapist in the MFT

setting may have a positive function for those self-blaming and critical families in the sense that they may feel less central as compared to the individual family therapy meetings.

This speculation may also be relevant to the discrepancy between the high patient/family satisfaction expressed in MFT as opposed to family therapy. As noted above, there is evidence to suggest (Squire-Dehouck, 1993) that part of the dissatisfaction with family therapy in anorexia nervosa is due to feelings of guilt and blame being associated with that sort of treatment. If MFT is more successful in addressing and alleviating those feelings then the high client satisfaction, across participants and irrespective of their EE levels becomes more understandable while making a substantial impact by keeping critical families in treatment.

Overall, the results of this study seem encouraging for the employment of MFT in the treatment of adolescent anorexia nervosa. Nevertheless, these results are only preliminary while there are various issues that prevent from drawing conclusions about the MFT's efficacy for bringing about patient as well as family change. These are very similar to the problems discussed with respect to the MFT's efficacy in the patients' outcome and include lack of a comparison treatment, short follow-up period and a sample size from which generalisations might prove difficult. Furthermore, future studies should be on an intention to treat basis in order to address the issue of how easy and/or difficult it is to engage families in the MFT treatment approach.

Despite these limitations though, this study has demonstrated that MFT appears to be beneficial for adolescent anorexia nervosa, at least in the short term, while its long term

efficacy is still to be tested by the employment of larger scale, RCT studies also adopting longer follow-up periods. Also, some positive changes in parental EE took place during the MFT with an associated relationship to the patients' symptomatic outcome. Lastly, patients and parents alike expressed high satisfaction with the treatment which is perhaps symptomatic of the small drop-out rates. This is particularly important as a common problem in family therapy for anorexia nervosa, otherwise found to be helpful, is engaging families and keeping them in treatment. With this respect the MFT approach might be particularly relevant for the treatment of adolescent anorexia nervosa by having the efficacy of traditional family therapy without one of its major problems, namely the difficulty to engage and keep families in treatment.

PART IV

OVERVIEW OF THE THESIS

CHAPTER 12

BRINGING QUALITATIVE AND QUANTITATIVE FINDINGS TOGETHER

The quantitative and qualitative components of this study have each provided substantial information and insight about families containing an adolescent suffering from anorexia nervosa while in MFT treatment. These have been extensively discussed in previous chapters of this thesis and will only be summarised here. Further to that, an attempt will be made in this section, to bring the two perspectives (quantitative & qualitative) together aiming to gain a deeper understanding of these families' processes during MFT.

At the quantitative level the MFT seems a promising approach for the treatment of adolescent anorexia nervosa. All patient variables assessed have improved significantly with weight gain at six months being comparable to that found after a year of family therapy (Eisler et al., 2000). Similarly parental criticism towards the patient reduced and patients and families reported high satisfaction with treatment.

The qualitative component further confirmed the treatments' acceptability with mostly helpful experiences being associated with it. Furthermore, it illustrated specific aspects of the treatment that were perceived to have a substantial impact upon participants in bringing about family and individual change. These included structural aspects of the group (such as support network and learning and identification from each other) as well as specific interventions and treatment setting, including the clinical team. The qualitative feedback

also highlighted treatment expectations and specific needs and difficulties encountered, especially by the parents (such as their sense of desperation and isolation) that need to be taken into account in any sort of intervention for anorexia nervosa.

One of the difficulties, inherent in MFT research, is differentiating between the possible therapeutic effects of each of its components (i.e. group and family therapy). Considering quantitative and qualitative findings under the light of each other might prove useful in that respect.

Parental criticism was found to reduce in this study, with this having a positive effect on patient outcome. Similarly and in contrast with precious findings (e.g. Le Grange et al., 1992; Eisler et al., 2000; Szmukler et al., 1985) initially critical families where not found to be more prone to drop-out and patients from such families were not more likely to have a worse outcome than their fellow-patients coming from less critical families. This was despite the conjoint and often confrontational nature of the MFT treatment speculated to play a role in the difficulties encountered when trying to engage these sorts of families (e.g. Dare et al., 1994; 1995). This difficulty has been attributed to feelings of guilt and blame associated with that type of therapy (Squire-Dehouck, 1993).

In this respect, parents have talked extensively about their feelings of guilt and self-blame for the onset and maintenance of the illness. They were also quite explicit about their sense of the MFT helping them address those feelings through the interaction with and support from the other families. What in other words Asen (2002) described as a feedback that is more credible when coming from fellow-suffering families rather than professionals. Similarly, parents talked about a 'normalisation' effect deriving from the observation of

and identification with the other families. In that instance parents begin to perceive themselves as 'normal' and as such not to blame for their child's illness.

A relevant process, also described to have occurred during the MFT, was the parents' increased empathy with their child and the understanding of the illness as something outside of the patient's control. This was described to have taken place through the observation of patients other than their own child. It is also interesting that this process taking place within the parents was anticipated and appreciated by the patients who said that they felt that the parents understood more what the illness felt like for them (patients). The presence of other families is central for the development of these dynamics and as such, difficult to achieve in individual family therapy.

The apparent increase in warmth between the parents is consistent with previous findings (Eisler et al., 2000) irrespective of conjoint or separated family therapy. This quantitative increase, in the present study, in the warmth between parents might also be qualitatively reflected in the parents' reports of feeling stronger and more united in their parental role. The fact that increases in warmth between the parents are identifiable across the various forms of family therapy (e.g. conjoint, separated, MFT) might indicate that it is more due to the family members', interaction with each other rather than the family's interaction with fellow families. This is also consistent with Krautter & Lock's (2004) findings from families in family therapy for anorexia nervosa who reported improvements in family closeness and communication. Nevertheless, the parents in the present study talked about the effect of the intensive nature of the MFT in facilitating the between family interaction in an uninterrupted and concentrated way that is difficult to have in weekly family therapy sessions or indeed the family's home environment. It might therefore be the case that

although between parents' interaction improves in any form of family therapy it is further amplified in the MFT context.

A few of the mothers also talked about the MFT enabling them to involve their partner more in the care of their child. Also, a couple of the mothers were quite explicit about the MFT providing a context for the patient to interact with father more than their usual degree. This might possibly be related to the slight increase in paternal EOI found to have a positive effect on patient outcome. In that instance paternal involvement might indeed be helpful both via supporting the mother and by directly improving the father-patient interaction.

Having considered the above, one could possibly speculate about the family's dynamic at entry to the treatment and how this might have changed during the MFT.

The depiction of these families as un-expressive emerging by their levels of EE becomes somewhat more understandable if one considers the parents' feelings of despair and hopelessness when entering treatment along with their profound feelings of guilt, blame and inadequacy in their parental role, all of which became apparent in the qualitative feedback. In other words, the parents' lack of affective expressiveness may reflect their withdrawal triggered by their inability to "see light at the end of the tunnel" combined with their sense that their child's illness is, at least partly, their fault.

The above is in agreement with speculations made in a previous chapter about family interaction being trapped into a vicious circle with guilt and blame and attributions of the illness as internal to the patient giving rise to a critical attitude. This critical attitude, despite

small in quantity, has a negative effect upon the patient, either due to its relative rarity which makes the patient more sensitive to criticism when this arises or due to the particularly hurtful content of the criticism or possibly both.

In this respect, the MFT seems to provide an environment where issues of guilt, blame and attributions of illness (as discussed in a previous chapter all of which found to operate in a dynamic way with parental criticism) are better contained and addressed making parents feel less blamed and possibly accounting for reduction of CC as well as high client satisfaction and low drop-out rates.

Therefore, a different family dynamic seems to be emerging in the MFT context whereby the parents, feeling less blamed and more empowered approach the patient in a different, more firm yet less critical manner. At the same time the patient having witnessed the parental increase in empathy (as reported in the qualitative feedback), becomes slightly more accepting of and/or giving in into the parents' efforts feeling less blamed for the family's misfortune while possibly feeling more secure faced with a more cohesive parental front.

Considering the qualitative and quantitative findings of this study provides enough evidence for the above speculation. As to the differential effects of group and family components in MFT it appears that both of them are at work during the treatment with their respective contributions to different areas of family functioning and interaction. Family therapy effects (such as improved interaction and communication within the family) seem to remain part of the MFT treatment while further enhanced and amplified by both the presence of the other families and the intensive nature of the treatment. Nevertheless, the

lack of a control group imposes that the above maintain their status as speculations rather than being induced into conclusions. Addressing these issues in studies comparing MFT with customary family therapy would be a useful step towards increasing our understanding of similarities and differences in family process during MFT and family therapy.

Another issue to be considered when bringing quantitative and qualitative findings together involves the patients' outcome as quantitatively assessed compared to the parents' reported perceptions. In that respect there has been somewhat of a discrepancy in that at the qualitative level, most parents tended to report that they have not yet seen any benefits of the treatment with respect to their child's illness while the quantitative findings indicated a clear improvement to have occurred. This discrepancy can be easily explained by the effect of the timing of the qualitative assessment being too soon (2-4 weeks following MFT) for clear improvements to have taken place. One could view that as a shortcoming of the study but it worth reminding that the time of qualitative assessment was purposefully conducted soon after the MFT so that notable improvements on the patients would not, as yet, have taken place. This was in order to gain access to the families' treatment experience without them being coloured by the actual outcome of their child. Nevertheless, an interesting question, possibly to be addressed in future research, involves exactly that: if and how is treatment experience affected by patient outcome. In other words, do families continue to view MFT as having been helpful irrespective of how the patient has done or do their perceptions change accordingly?

However, when the parents reported lack of clear improvement in their children they did not seem to be disappointed; instead they embraced the treatment's helpfulness as a first step towards recovery. In a sense, this very feeling of optimism and potential while

acknowledging the gradual nature of the recovery process might have further added to the above mentioned shifted family dynamic potentially contributing to the patients' later improvement as indicated by the quantitative data.

As discussed in the relevant qualitative section, overall, parents were more articulate about their treatment experience than were the young people. This is somehow consistent with the quantitative finding suggesting that although both parents and patients scored high in client satisfaction, patients were significantly less satisfied with the treatment than their parents. The fact that patients were less articulate than their parents was described (in a previous chapter) as possibly due to an age effect which might also be the case for the quantitative difference between parents and patients in client satisfaction. In other words, the parents, being older, might have been more insightful as to treatment processes and ways in which these were helpful; hence more articulate about their experience and more satisfied with the treatment. Another possibility however, could be that of the MFT being more of a parent directed treatment whereby the patients do benefit, albeit indirectly and via the positive effects of the MFT upon their parents. Indeed this was the account of some of the parents perceiving the MFT as helpful to themselves and as such helpful to their children.

Another interesting issue was that the themes that emerged by both parents and patients and whether they were perceived as helpful or unhelpful did not seem to relate to the EE levels of the families. This possibly indicates that the experience of the MFT for these families mainly involved the similarities between them (such as similar struggles and painful experiences) rather than their differences in terms of family interactions. Similarly, given the association between high-EE and treatment drop-out (Szmukler, 1885) one would possibly expect that high EE relatives would be more likely to view the treatment negative

than low-EE relatives. This however was not the case in the present study which along with the lack of drop-outs and decrease in parental criticism might indicate that the MFT is acceptable and potentially useful even for those high EE relatives.

The methodological shortcomings of each of the two methods have been discussed in the relevant sections of this thesis and will not be repeated here. However, there is scope in discussing the adequacy of bringing qualitative and quantitative findings together along with their relevant limitations.

As discussed in a methodology section of this thesis quantitative and qualitative enquiries come from completely different and, in a sense, competing paradigms. The former being geared towards the examination of falsifiable hypotheses, expressed numerically with objectivity and standardisation of instruments as well as generalisability of findings being of paramount importance. Qualitative approaches on the other hand are more involved with the exploration of subjective experience whereby processes of understanding and interpretation constitute the main scientific apparatus. There have been recent calls for the more collaborative employment of the two methods, especially in health care research (e.g. Cuba et al., 1994; Silverman, 2001) in order to address the variety and multiplicity of issues involved that are difficult to examine if one confines themselves into one of the two methods. This was indeed the purpose of the study in terms of being driven by the specific questions and issues addressed rather than being limited in the questions to be addressed, by an a-priory decided methodology. However, given the respective differences between the two methods, bringing their findings together is not an easy task and the possible limitations need to be considered.

The attempt made in this section to bring quantitative and qualitative findings together should not be seen as aiming to the generation of unequivocal and generalisable conclusions. This would be impossible given that, firstly, it is only quantitative enquiry that aims towards that objective while qualitative findings can only be seen as representing a description of experience of the specific families involved. Furthermore, the lack of a control group makes it difficult to draw unequivocal conclusions about the efficacy of the MFT treatment with respect to improvement in family processes as well as patient outcome. Similarly, the uniqueness of the described helpful experiences in the MFT context as well as their actual contribution to therapeutic change are difficult to establish. Taking these into account, one could view the results of the quantitative and qualitative components as providing a relatively comprehensive account of the specific families under the specific treatment.

Furthermore, this study has shown that MFT is an acceptable and potentially useful treatment for adolescent anorexia nervosa, the long-term benefits of which as well as its possible therapeutic superiority to other forms of treatment are still to be tested. Similarly, the consideration of quantitative and qualitative findings under the light of each other has generated some speculations about family processes in anorexia nervosa as well as potential family changes during treatment. These might prove useful, in terms of generating hypotheses to be formally tested by future research. As for the qualitative feedback obtained by the families, it can be seen as representing a step towards the identification of possible effective aspects of the intervention while it certainly uncovered some of the fundamental needs and problems the families struggle with and which need to be taken into account in future interventions. Further to that and consistently with the high patient and family satisfaction, the qualitative findings had shown that MFT processes tend to be

experienced positively and perceived as helpful by most families irrespective of individual patient and family differences. On the other hand, perceived unhelpful aspects of the treatment seem to be rather idiosyncratic.

Overall, this study could possibly be summarised by the metaphor of trying to "draw a picture" of these families during MFT treatment. In that respect the quantitative component can be seen as having provided the pencilling in of the shapes of the picture while the qualitative part has contributed the colour. Nevertheless, substantial contributions are still needed, both in terms of shape and colour, before the picture is complete.

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APPENDIX I
EXAMPLES OF MFT DAYS

Day 1

9.30 – 10.30	Multi-family group introduction (interactional and 'gossiping')
10.30 – 11.00	**Morning Snack:** Tea, soft drinks, biscuits and fruit
11.00 – 12.20	**Parents:** planning of the day's lunch **Offspring:** 'Portraying Anorexia' –draw model or write something that symbolizes anorexia for you/your family (gains and losses for me and my family from anorexia)
12.30 – 2.00	**Family Meals:** Families eat together supported by staff
2.00 – 3.30	Extensive feedback of all families to each other
3.30 – 4.00	**Afternoon Snack:** Tea, soft drinks, biscuits and fruit
4.00 – 5.00	Reflections on the 'portrayals of anorexia'

Day 2

9.30 – 10.00	Multi-family feedback on supper and breakfast
10.00 – 10.30	Prepare food collages (collage of food images from magazines on plate)
10.30 – 11.00	**Morning Snack:** Tea, soft drinks, biscuits and fruit
11.00 – 12.30	Role reversal – role play (patients pretend to be their parents and try to feed their child, enacted by a parent, what they have prepared in their food collages
12.30 – 2.00	**Family Meals:** Families eat together supported by staff
2.00 – 3.30	**Offspring:** Pros and cons of anorexia staying (siblings, parents and young people who are sufferers) **Parents:** Ventilation and sympathy to gain support from each other for moving on
3.30 – 4.00	**Afternoon Snack:** Tea, soft drinks, biscuits and fruit
4.00 – 5.00	**Whole group:** Discuss issues form young peoples' group

APPENDIX II

OPEN-ENDED INTERVIEW QUESTIONS

- Let me start by asking what was your overall, general impression from having taken part in the MFT.

- Did specific things happened during the MFT that you thought were particularly helpful for your son/daughter (if parent)/ for yourself (if patient)?

- How about the family? Did specific things took place during the MFT that you found particularly helpful for yourself as parent(s) and your family (if interviewing parent)/ for your parents and your family (if interviewing patient)?

- What are your thoughts about the group as a whole. Did specific things happen during the MFT that you found to be helpful for the entire group as a unit?

- I would now like to ask you to think about aspects of the MFT that you thought were unhelpful. Did specific things happen that you thought were unhelpful for your son/daughter (if parent)/ for yourself (if patient)?

- In terms of you as parents and your family (if parents)/ your parents and your family (if patient), did specific things happen in the MFT that you thought were unhelpful in that respect?

- How about the group as a whole? Did specific things took place during the treatment that you thought were unhelpful for the group as a unit?

- How about things you might have liked to be different in the MFT? If any.

- Is there anything else you would like to add, before we finish, regarding your experience from the MFT?